DOMINA RERUM SAPIENTIA

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Selections from Society Proceedings.

FRANCE.

CONGRÈS FRANÇAIS DE CHIRURGIE.

Surgery of the Lungs.—M. RECLUS, in introducing a discussion on this subject, stated that pulmonary affections susceptible of surgical interference might be grouped into three distinct classes: hæmorrhages, traumatic or pathological (ligature); tumors, represented by tuberculosis and cancers (extirpation, pneumectomy); and cavities filled with purulent matter, as in phthisis, circumscribed gangrene, abscess, hydatid cysts (incision, pneumotomy). Intervention for traumatic hæmorrhage is very rare. Omboni, of Cremona, however, has published one case; his patient survived seven days; and MM. Delorme and Robert had attempted ligature in another case, but the patient succumbed a quarter of an hour afterward, from anuria and shock. In spite of these failures M. Reclus thought that the operation was warranted, if other means did not succeed in arresting the hæmorrhage. Pneumectomy had been tried to extirpate cancerous or tuberculous masses. Krönlein had operated on two patients; one died in a few hours and the other on the ninth day. Ruggi had had two similar failures, but Tuffier reported a brilliant success in 1891; his patient recovered and a year subsequently was found to be in good condition. Two years later Lawson published another successful case. However, in the speaker's mind, such an operation will never be sanctioned by the profession. Pneumotomy, or incision of the lung, has been frequently practiced for hydatid cysts, and with considerable success; and the same may be said for abscess of the organ.

M. TUFFIER presented the young man alluded to by the previous speaker. At the time of the operation he was 25 years of age, and presented all the signs of phthisis localized at the summit of the right lung, and without any trace elsewhere. Having heard that the speaker had already operated with success for pulmonary hernia, the man came to him to know if the extirpation of his lesion were possible. The patient having accepted all risk, the speaker made an incision in the first intercostal space, and having detached the parietal layer of the pleura to a considerable extent the summit of the lung bulged up through the wound. A rapid inspection revealed the tuberculous patch, which was excised and the lung returned. The wound was closed without drainage. Nine days afterward the patient could be presented to the Surgical Society. Examination of the expectoration previous to the operation, and of the resected portion subsequently, clearly proved that it was a case of tuberculosis. Since that time the man has been in perfect health.

M. Michaux successfully operated in a case of wound of the lung by pistol-shot. In November last a young man of 18 shot himself in the left side about two inches from the nipple. The following day the general condition was grave: face livid, pulse wiry, and dyspnœa; a considerable effusion of blood was found to exist in the pleural cavity. M. Michaux resected the seventh and eighth ribs and incised the pleura, removing a quart of blood. Through the cavity could be seen the lung in function and from which flowed a small stream of blood mixed with air. In turning up the edge of the inferior lobe the operator perceived a wound deeply seated, which he plugged, and, having placed two drains in the pleura, he closed partially the parietal incision. A considerable improvement was observed during the first four days, and gradually the patient entered on convalescence and is now quite well.

Resection of the Vas Deferens.—M. Guyon, in discussing the treatment of hypertrophy of the prostate by this method, stated that the solidarity existing between the testicles and the prostate gland was purely functional, for the circulation and enervation of both of these glands were independent and different in their origin. It was, consequently, natural to suppose that the physiological isolation of these organs by the suppression of the vas deferens would be sufficient to obtain effects analogous to those realized from ablation of the testicles. He practiced last June bilateral resection of the vas deferens on two patients, the first of whom had suffered for ten years from incomplete retention, and when, last summer, he consulted the speaker, micturition had become so imperative that the catheter had to be constantly used, more than once wounding the canal in effecting a passage through the prostatic portion of the urethra. Rectal examination revealed considerable hypertrophy of the prostate. A few days after the operation the frequency of micturition diminished notably and the catheter could be passed with more ease. At the end of a month the gland had decreased in volume. The second patient came to him in about the same condition, and the operation gave a certain relief, but the prostate had not changed much in volume. In both patients the testicles remained normal. His colleague, M. Legueu, performed the same operation on a patient who had suffered from complete retention for a month previously. The results of the operation were quickly manifest; the man was able in a month to dispense with the use of the catheter for ten days at a time.

In concluding, M. Guyon said that the operation, although it could not pretend to the radical cure of hypertrophy of the prostate, as did that of total castration, might yet take rank among those measures intended for the relief of certain complications of the affection.—*Medical Press and Circular*, October 30, 1895.

Société des Hôpitaux.

Persistence of the Diphtheritic Bacillus in the Nasal Cavities.—MM. le Gendre and G. Pochon had a child under observation for fifteen months who had had three attacks of diphtheria in less than three years (first angina, then stomatitis with pseudomembranous rhinitis, and again rhinitis with angina). Methodical bacteriological examinations of the nasal and pharyngeal mucus were made thirteen times since September, 1894, and the Löffler bacillus was found, at times virulent, then again non-virulent (not fatal to guinea-pigs); occasionally under the form of bacilli of medium size; occasionally small, and even the "Brisou" coccus, sometimes alone and sometimes associated with staphylococci, being present.

Frequent washing out of the nasal and pharyngeal cavities with a 5-per-cent. solution of Labarraque's solution causes the bacilli to temporarily disappear or to greatly diminish in numbers, but as soon as the irrigations are stopped for a time the child, usually gay and healthy, becomes sad and loses appetite and color; fresh cultures once more reveal the microbe, which has, therefore, apparently been hidden all this time in some glands of the nasal mucous membrane. The authors regard this as a very striking case of latent microbism, but similar cases are perhaps more common than is now believed, for it is very rare that the bacteriological examination can be continued for such a length of time.—*Bull. Méd.*, December 15, 1895.

Gastric Digestion After Gastro-enterostomy.—Theoretically, it is natural to suppose that the stomach, when placed in communication with the small intestine, as in gastro-enterostomy, becomes unfitted to retain food during the necessary period, and that hence the gastric functions become abolished. Professor Hayem, however (*Bull. Méd.*, November 10, 1895), has found that this was not the case with two patients in his clinic who had undergone gastro-enterostomy for grave pyloric stenosis. He claims that the operation can only become an obstacle to the performance of the chemical functions of the stomach by rendering impossible the retention of food for the time necessary for chemical digestion. In one of his patients the gastro-intestinal fistula resulting from the operation did not correspond to the lowest-inclined point of the stomach, and this is probably the case in many such operations.

M. Albert Mathieu, at a subsequent meeting, presented two cases which had led him to form similar conclusions, and stated that the recent researches of Rosenheim in analogous instances demonstrate that the motor functions of the stomach are of more importance here, as in many cases of dyspepsia, than are the chemical functions. The patients may continue to do well as long as the evacuation of the stomach-contents into the intestine goes on, even though the chemical properties of the gastric juice have diminished. In spite of this fact, it is not without interest to note that the functions of the stomach are not completely destroyed by gastro-enterostomy.

SOCIÉTÉ FRANÇAISE DE DERMATOLOGIE ET SYPHILIGRAPHIE.

Curative Effect of Erysipelas in Lupus.—M. HALLOPEAU stated that he had, for some years past, been convinced of the curative action of erysipelas in lupus, and had even proposed opening an isolation clinic for the treatment of lupus by inoculations of benign erysipelas, only intervening in case the erysipelas appeared to be taking a serious form, either by the use of inoculations of erysipelas toxins or by applications of ichthyol. He presented before the society a woman who had been cured of grave lupus of the face six years previously, after an attack of erysipelas, and who had presented no sign of relapse since that time.

M. BESNIER stated that, at the Saint-Louis Hospital, several patients with lupus had been seen suffering from erysipelas, but, although he admitted that some of them seemed to be cured, he had also often seen lupus remain after an attack of erysipelas. M. Hallopeau's patient was suffering from disseminated tuberculous lupus,—a kind which is comparatively easy to cure. He believed that, in the present state of science, inoculations of streptococci cannot be authorized as a general method of treatment for lupus. In the great majority of cases thus treated, all the benefit obtained has been a temporary cessation of the progress of the cutaneous tuberculosis. To obtain this very insufficient result, the patient is exposed to all the dangers of an intercurrent disease which may be very serious, for when benign erysipelas is inoculated a very grave form may result.

M. HALLOPEAU asserted that his patient had suffered from a severe form of lupus, as was shown by the cicatrices. The inoculation of erysipelas is, perhaps, a daring treatment, but in such a terrible disease everything should be tried.

M. BARTHÉLEMY was certain that it would be difficult to control the treatment by erysipelas. One of his patients had an attack of erysipelas following scarifications of nasal lupus; the disease, at first benign, was afterward complicated by phlebitis of the sinus and ended fatally.

M. MAURIAC stated that, when intercurrent erysipelas supervenes in syphilis, the lesions retrograde and even disappear, but this cure does not last, and the syphilitic diathesis soon returns; so that, though he believes that erysipelas has a beneficial action on the evolution of syphilis, he would never advise it as a treatment, since erysipelas may be very dangerous.

M. WICKHAM had seen erysipelas cause elephantiasic thickening of the face twice in the same patient.

M. FOURNIER agreed with M. Besnier, that erysipelas only exerts a simple inhibition on syphilis or lupus. He recalled the case published by Ricord, of incurable phagedænic chancre, apparently cured after an attack of erysipelas; the unfortunate patient, seeing the wound almost completely closed, believed himself cured, but the chancre soon recommenced its invasions.—*Bull. Méd.*, December 15, 1895.

Recurrent Gonorrhœal Rheumatism.—Dr. Emery presented a man who had for the nineteenth time had gonorrhœal rheumatism and ten attacks of gonorrhœa. The first attack of gonorrhœa occurred in 1876; it was after the fourth (in 1878) that he had seven successive attacks of rheumatism, which left considerable deformity of the feet, resembling that of chronic polyarthritis deformans, and a deformity of the middle finger which assumed the shape of a radish.

M. Mauriac recalled, in this connection, the history of a man who had during twenty-one years an annual attack of gonorrhœa accompanied with rheumatism.

M. Fournier once had under his care a young man in whom each sexual act, even though means were taken to prevent infection, infallibly provoked an attack of rheumatism. Here there was no question of a fresh attack of gonorrhœa, the sexual orgasm sufficing to relight the joint pains. This would seem to support the medullary theory of the affection, and M. Gastou cited a case of blennorrhagic rheumatism where there was present disseminated muscular atrophy outside the articular area, which atrophy was considered by M. Oudin as being of medullary origin. M. Fournier remarked that directly he saw Dr. Emery's patient he diagnosed gonorrhœa from the radish-shape of the deformed fingers. A similar deformity exists in arthritis deformans, but in the latter disease all the digits are deformed, whereas in the gonorrhœal type only one or two are involved.—*Lancet*, December 12, 1895.

GERMANY.

Verein fur Innere Medizin.

Sudden Death from Occlusion of the Coronary Arteries.—Herr Oestreich related a case of this kind in an officer, aged 32, who had always been healthy and who died suddenly on his wedding-night. In the ascending aorta several very small atheromatous ulcerations were found upon post-mortem examination. Upon one, lying near and just above the point where the right coronary artery was given off, was a pediculated thrombus the size of a cherry-stone, which hung down and closed the vessel. The thrombus consisted of an older and a newer portion, the latter apparently quite recent. The left coronary artery contained an embolus one centimetre in length, resembling the older part of the one just mentioned. The heart was otherwise healthy and the other organs were sound.

Herr Leyden said that occlusion of both arteries was very rare, the left being usually affected. He had only seen the right affected once, in an old lady. He had seen four cases in which sudden death followed intercourse, but in all the cases connection had been illicit.—*Medical Press and Circular*, December 25, 1895.

Dilatation in Stricture of the Urethra.—Herr Wossidlo, in an address on this subject, said that, in the ordinary treatment of stricture of the urethra by dilatation, the patient was considered cured when Nos. 24 or 25, or at most 28 to 30, Charrière's sound could be passed. He claimed, however, that even such patients could not be looked upon as cured, as when examined with the endoscope what Oberlænder called "a hard infiltration" could always be seen. The dilatation, in order to effect a real cure, must be carried to higher numbers, by passing an Oberlænder or Kollmann dilator once in ten days, going one number higher each time. This was to be done not with the view of roughly rupturing the stricture, but of promoting gradual absorption of the infiltration, which takes place with a more or less copious secretion. If the secretion become profuse after stretching, or if urethritis be set up, a mistake has been made and the treatment carried too far. The secretion is, however, readily controlled by washing out with a 0.5- to 1-per-cent. solution of nitrate of silver.

The steps toward recovery should be followed with the endoscope, and it would be found in most cases that the greater the dilatation, and, above all, the more slowly it had been performed, the more had the mucous membrane returned to a normal state. In view of a relapse the patient should be again examined at the end of three months. A commencing relapse is easily recognizable with the endoscope and relieved by a new dilatation. Recovery would generally be then permanent. Of course, only dilatable strictures were suitable for this form of treatment. For resilient and hard callous stricture internal urethrotomy must be performed.—*Medical Press and Circular*, December 11, 1895.

GREAT BRITAIN.

Royal Academy of Medicine in Ireland.

The Management of Cases Immediately After Operation.—Sir Thornley Stoker, in an address delivered at the opening of the Surgical Section for the session of 1895–'96, demonstrated the growing tendency to prolong operations, due in part to the facility afforded by anæsthetics and in part to the extreme care, conservatism, and attention to detail begotten by the introduction of antiseptic methods. Prolonged operations are always a grave source of danger, and cannot be too carefully guarded against. There is no circumstance which so tends to the production of shock and exhaustion from the production of vomiting as prolonged anæsthesia, post-operative vomiting being generally proportionate in severity and persistence to the duration of anæsthesia. As to the treatment of these conditions, the speaker said that no help could be expected from the stomach, and that the rectum must therefore be relied on as its substitute. He has learned to rely on three agents only for relief of shock: (1) heat; (2) alcohol; (3) morphine or opium. If the surface of the body can be brought to a wholesome warmth by the use of hot applications, the danger may be regarded as overcome. Rubefacient applications of mustard to the extremities, about the region of the solar plexus or over the heart, form a valuable aid in producing not only heat, but physiological stimulation. Should these measures fail, he would resort to alcohol, given by the rectum, the bowels having, of course, been thoroughly cleared before the operation. If alcohol fail, and a rapid result is desired, he would recommend morphine hypodermatically, especially if there be vomiting; but where there is no vomiting and the stimulating effect of the drug is the principal object, opium is preferable, given by the rectum. In its administration, two points should be borne in mind: first, that persons suffering from shock tolerate large quantities of opium, as do those who have lost considerable blood; second, that it must be given watchfully, dose after dose, until the due effect is produced.

Drugs of the class ordinarily used to check vomiting have, in his experience proved of little or no use in cases of this kind, and he has found hypodermatic injections of morphine the cardinal remedy. If used intelligently, fully, and fearlessly, it will exercise its effects both as a stimulant and gastric sedative beyond those of any other remedy. In regard to the distressing symptom of thirst, the speaker has learned to discredit thoroughly the value of ice, finding that it increases the thirst and does harm by introducing water into the stomach, and so producing vomiting. The symptom is best relieved by frequent rinsing of the mouth with hot water and by occasional introduction of 2 or 3 ounces (60 to 90 cubic centimetres) of warm water into the rectum.—*British Medical Journal*, December 7, 1895.

Tumors of the Kidney Composed of Suprarenal Tissue.—Dr. McWeeney described two new cases of this condition, which has hitherto escaped notice from English-speaking pathologists. His first case was that of a left kidney successfully removed by Mr. Coppinger at the Mater Misericordiæ Hospital, in March, 1892, from a woman, aged 53, who is still alive and well. The lower part of the kidney was converted into a large cyst, from which a bowlful of brain-like, hæmorrhagic material was evacuated during the operation. The walls of the cyst were ragged and covered with adherent masses of tumor-tissue. The second case was that of a woman, aged 38, from whom a huge mass of confluent tumor-nodules, occupying the position of the left kidney, was removed by Mr. Lentaigne at the same hospital, last September. The only recognizable part of the kidney left was its upper extremity. The nodules were not unlike liver in appearance and consistency; many were as large as the closed fist; all were distinctly encapsuled, and none showed signs of advanced degenerative change. Microscopically these two tumors agreed in their close resemblance to the suprarenal cortex. They consisted of large, polygonal epithelial cells, with a small, round, centrally-placed nucleus, arranged without intercellular substance in elongated rows or circular groups separated by blood-capillaries. The tumor-cells were placed directly on the capillary wall, which simply consisted of a line of endothelial nuclei. In the first tumor the deposition of fat and glycogen was a marked feature. There was but little fat and no glycogen in the second. This would appear to show that the deposition of glycogen is not, as Lubarsch supposes, an essential feature of tumors of this kind, but is merely associated with retrogressive change. The origin of certain tumors of the kidney from suprarenal remains was first pointed out by Grawitz in 1883. His results were extended and generalized by Horn, Beneke, and Askanazy. The speaker agreed with Lubarsch, that they must really be considered as derived from dislocated suprarenal elements. He discarded Virchow's expression, "struma," as applied by Grawitz to these growths. Attention was drawn to the fact that English writers, such as Rolleston, speak of adenoma and carcinoma of the suprarenals, while admitting their mesoblastic origin. The relations of embryology to tumor classification must be further cleared up before we can place these growths either among the sarcomata or the carcinomata. Thirty-two such cases are now on record, many of which took a malignant course and formed metastatic deposits in various organs. Nephrectomy had proved fatal even in the absence of peritonitis and uræmia. In one of the cases now brought forward, two pounds of morphologically perfect suprarenal cortex, free from degenerative change, were present in the body, —a fact not without significance, in view of the high physiological activity now known to be possessed by this tissue. Perhaps the system had had time to become acclimatized during the growth of the tumor. He had no doubt that many cases belonging to this category had occurred in England, but had been recorded under different names.

Dr O'Sullivan said that when in Vienna last summer he had seen two of these growths, one of which was like Dr. McWeeney's first case,—an encapsulated mass, confined to the upper part of the kidney,—and consisted of pultaceous material infiltrated with blood. There was no metastasis. No microscopical examination was made. The other was of more pathological importance, since in the kidney itself there were several masses of the same character, but also a considerable amount of metastasis in the bones. A piece of the tumor in one of the bones was taken and pressed out on a slide, when the cells were seen to be arranged in fasciculæ. The hæmorrhages seemed to be very frequent, and might be compared to the hæmatoma so frequently met with in the suprarenal. He could not imagine these tumors spoken of as lipomata.

The president, Dr. Connolly Norman, said that a case had been published in the *Journal of Pathology*, about three years ago, by Kanthack and Rolleston, resembling in many ways that of Dr. McWeeney's. Another case was published in France, in 1882, of adenomata of the kidney. It was argued that adenomata of the kidney were almost invariably associated with a cirrhotic condition of the organ. He had himself brought before the academy a somewhat similar case,—that of an elderly man who was dying of cirrhosis of the kidney. There was a tumor projecting from the right kidney, about the size of a small kidney-bean. It was not accompanied by metastasis, and consisted of double rows of cylindrical, epithelial-like cells, which contained toward their base a well-staining nucleus. The rows of cells were in some places like convoluted tubules. It was separated from the degenerated kidney-substance by a dense fibrous capsule. There were numerous hæmorrhages and spaces lined by delicate endothelium; some contained blood and some were empty. There was a great deal of fat. He thought it possible that the confusion which attended the subject might be accounted for by the fact that different tumors were included under one name.

Dr. McWeeney, in replying, stated that in both of his cases the tumor originated in the lower end of the kidney. Because adenomata occurred in a cirrhosed kidney, it did not follow that they were caused by it. The fully-formed tissue of these tumors is not like that of urinary tubules. In the cortex of the human suprarenal tissue, but more especially in that of the higher mammals, pseudotubular structures of the same kind had been found by Creighton, Marchand, and others.—*Medical Press and Circular*, December 25, 1895.

Clinical Society of London.

Colotomy for Membranous Colitis.—Dr. W. Hale White and Mr. C. H. Golding-Bird reported the case of a neurotic woman, aged 30, who first began to pass mucus from the rectum and suffer from constipation in 1885. From that time both these symptoms became more marked, and by 1891 she was suffering from severe abdominal pain. In the next year the motions often consisted of nothing but mucus and blood, and the pain was agonizing. This state of things continued until 1894, when she began to pass tubular casts; the pain kept her in bed most of the day. Very strong purgatives were necessary to move the bowels, and she was a complete invalid. When seen by the authors in 1895 she was in the same condition, and had much tenderness over the descending colon and sigmoid. A motion was examined and found to consist of little fæces, much mucus, long tubular casts, and a considerable amount of blood. As during the previous ten years all sorts of drugs, various diets, prolonged rest in bed, and many health resorts had been tried, it was decided, with the consent of Dr. Walter Smith, of Dublin, to perform a right colotomy. The bowel was fixed to the surface on May 10th and opened on May 17th. Three days later the colon was washed out from the artificial to the natural anus with hot water, but already the membranes had ceased to be formed. For five weeks all the motions were passed through the artificial anus without the aid of purgatives. The fæces always appeared normal. As at the end of this time all the original symptoms had disappeared, the colotomy wound was closed and the bowels were subsequently kept confined for a week with opium. Some compound liquorice-powder was then given and the motion which was passed contained neither mucus nor blood. The general health and strength improved, and she went into the country, on July 24th, feeling better than she had done for many years, having passed no blood or mucus since the operation on May 10th. The authors submitted that in a severe case of membranous colitis this treatment was justifiable and rational, for by it the colon could have complete rest. Their patient, it was true, had since died, but, as far as could be made out, her death had nothing to do with the operation or the colitis.

Dr. Adeney, of Tunbridge Wells, had attended the patient in her final illness, which occurred nearly two months after her departure from London. She died, after about forty hours' illness, with symptoms of acute suppurative general peritonitis, due apparently to the rupture of something in the pelvis, possibly a suppurating gland. A post-mortem examination could not be obtained. The patient before death stated that the improvement in her condition which had been attained when she left for the country had continued until her final sudden seizere.

Mr. Godlee said that the treatment of dysentery by colotomy had been suggested to him years ago by Dr. Manson. This year he had put the suggestion into practice. The patient had had dysentery in India, and fistula, for which he operated. She became better, then had phlebitis after childbirth, and suppuration of the liver, from which she recovered ; but the dysentery recurred, and he performed left colotomy. This, however, he found did not allow such complete treatment of the bowel as did right colotomy, which for the future he should prefer. On opening the gut the mucous membrane was found to be completely studded with small polypoid growths. The dysentery and the patient's general condition were much improved, and she was relieved from the constant irritation. She eventually died from some return of the phlebitis, which had nothing to do with the dysentery.

Dr Turney said that Mr. Ballance had operated on a case of his which was diagnosed as dysentery. The man had been in India, but had no dysentery there. Subsequently he passed blood and mucus from the bowel and became greatly emaciated. There was difficulty in fixing the appropriate time for the operation, so as to be neither too soon nor too late. Unfortunately it was a little too late. The operation was done on the right side by an inguinal incision. The ileum was completely cut through, the upper end being fixed to the wound. The lower end was reserved for irrigation. The patient recovered satisfactorily from the operation, the bowel was douched frequently, and he seemed to be improving when hypostatic pneumonia showed itself, and he died a week after the operation. The chance of recovery from severe dysentery under ordinary treatment was, he thought, almost hopeless, as the raw surface of the gut allowed the absorption of poisonous products which hastened the patient's death. The operative treatment, however, should be limited to cases in which the disease existed only in the large intestine. He considered colotomy preferable to division of the ileum.

Dr. Francis Hawkins, of Reading, while admitting that the casts in the authors' case came from the colon, thought that the term " membranous colitis " should not be used, because casts similar in structure came also from the jejunum and ileum, as he himself had seen. The casts consisted of mucus, and he would describe the malady as a type of " mucous disease of the intestines." He doubted if it were so rare as some thought it, and considered that it might pass undetected when the stools were not systematically examined. He would advise operative treatment for intractable forms of the disease only, and thought it would be rarely called for. He cited a case where casts had been passed for a year and in which recovery took place, so that for two years no further casts had been passed.

Dr. Herringham considered that the casts were not the cause, but the consequence, of the disease, inasmuch as they usually followed a long period of constipation. They were quite structureless. He had seen two cases. The patients had great pain, with swelling on the left side of the abdomen; one recovered, one died after operation from an abscess in the neighborhood of the descending colon. Why should patients have an abscess there, except from some retention of fæces leading to ulceration? In the fatal case there was a pin-hole opening into the bowel; in the other case the pus was sweet, and apparently there was no communication with the bowel. A German writer had called the condition "pericolitis sinistra" and had asserted that it was as common as suppuration about the appendix. He suggested that, possibly, such suppuration was present in the authors' case, breaking into the peritoneum and causing the fatal termination.

Dr. S. Phillips said that the case under discussion was colitis, not dysentery. The casts mentioned by Dr. F. Hawkins might come without any disease of the mucous membrane, being structureless and quite different from the sloughs of mucous membrane found in colitis, which were accompanied by much hæmorrhage. Further, with colitis there was often disease of the small intestine as well. He could but notice that the end of all the three cases treated by operation which had been related had been fatal.—*British Medical Journal*, December 21, 1895.

Edinburgh Obstetrical Society.

A Rare Form of Abortion: Expulsion of the Amniotic Sac, with Retention of the Chorion and Decidua.—Dr. F. W. N. Haultain, in his paper on this subject, showed three illustrative specimens. I. Amniotic sac of the size of a large orange, no embryo, cast off from a patient believed to be three months pregnant. The decidua and chorion were removed some days later for uterine hæmorrhage. II. Amniotic sac of the size of a large goose-egg, containing embryo about the eighth week of development, granular *débris* cast off from a patient supposed to be three and a half months pregnant; the decidua, with chorion attached, was removed seven weeks afterward for symptoms of profuse, constant, watery discharge and irregular hæmorrhages. III. Amniotic sac of the size of a turkey's egg, embryo about the eighth week of development, but he was unable to give a clinical history. These specimens were of interest on account of their want of description in popular midwifery works and the thus scanty knowledge of the possibility of the occurrence of such a form of abortion. The mechanism of production from the specimens shown undoubtedly pointed to: 1. Pre-existing disease and death of the embryo, with, in the first two cases, a continued increase of liquor amnii. 2. Detachment of the amniotic sac from the chorion, thus forming an intra-uterine foreign body, setting up uterine contraction by irritation. 3. Rupture of chorion with expulsion of the sac, the adherent chorion remaining attached to the still vascularized and healthy decidua. 4. Occasional continued growth of decidua lined by chorion. This, when cast off, forms a variety of the so-called carneous mole, and accounts, in many instances, for the presumed absorption of the fœtus so commonly met with in these moles. The condition was clinically interesting as showing how abortion might take place with a minimum of detachment of the decidua and thus a minimum of hæmorrhage.

Viburnum Prunifolium and its Value in the Treatment of Dysmenorrhœa.—Dr. Theodore Sherman detailed his investigations into the botany, chemistry, and pharmacology of the drug. He used the liquid extract evaporated down and given in capsules. The drug seemed to diminish reflex pain, to lower blood-pressure, and to act as a uterine sedative. It was of great value in certain forms of dysmenorrhœa, in threatened abortions, etc.

Dr. William Craig had for years maintained in his lectures its preeminent value in abortion, and had used it in his practice.

Prof. A. R. Simpson had frequently used it with good effect in certain cases of early abortion, and in dysmenorrhœa of non-obstructive forms.

Dr. Haultain thought it was a direct uterine sedative, and was of value in the first stage of labor, in after-pains, in dysmenorrhœa with clots, and in abortion where there were pain and a little hæmorrhage.—*British Medical Journal*, December 21, 1895.

UNITED STATES.

Southern Surgical and Gynæcological Association, Washington.

Hysterectomy in Puerperal Sepsis.—Dr. A. M. Cartledge, of Louisville, in reporting two cases, advanced the following conclusions: 1. From our present knowledge of the causation and nature of puerperal infection, we may say it is largely a preventable disease. 2. It is of the greatest importance to differentiate between puerperal intoxication or invasion of a piece of putrescent placenta or blood-clot by saprophytic germs and true septic infection or invasion of living cells by pathogenic bacteria. Puerperal sapræmia, though in many cases producing the most alarming symptoms, is usually amenable to energetic treatment by curettage, antiseptic irrigation, and satisfactory tubular drainage of the uterine cavity. 3. True aseptic infection should be treated by sterilization of the birth-canal at the earliest possible time, free elimination by purgation, and prompt evacuation of superficial abscess-accumulations about the cervix. Such a course may save the patient from more radical measures. 4. The chief differential points between puerperal intoxication and true puerperal infection are the comparative absence of pain, tympanites and abdominal tenderness, and the more sudden onset and severe character of the symptoms in puerperal intoxication. Hysterectomy, as a primary measure, is never justifiable in septic intoxication, and when necessary it can only be after the mixed or secondary infection which may follow in the track of a primary sapræmia. 5. Progressive involvement of the deeper structures, as evidenced by daily elevation of temperature, probably 103° F. (39.5° C.) in the evening and subnormal in the morning, together with night-sweats, scanty secretions, and ascending pulse, are indications for hysterectomy. 6. It is often impossible, from the involvement primarily of the low pelvic structures, to make a bimanual examination which will reveal the true condition of the uterine appendages; but, in view of the fact that these structures are not so prone to be invaded in the acute violent type of the disease, vaginal hysterectomy should be the operation of selection.—*Journal of the American Medical Association*, November 30, 1895.

Comparative Frequency of Stone in the Bladder in the White and Negro Races.—Dr. George Ben Johnston, of Richmond, Va., read a paper on this subject. The common statement that stone in the bladder is of rare occurrence in the negro race being at variance with the speaker's own experience, he instituted an investigation on the subject, selecting the States of Virginia, North Carolina, South Carolina, Alabama, Georgia, Tennessee, Kentucky, Florida, Louisiana, Mississippi, Arkansas, and Texas as the field of inquiry, and communicating with four hundred representative practitioners. He received three hundred and thirty-eight responses, and succeeded in collecting 1068 cases of stone in the bladder. Of these, 952 were in white subjects and 116 in negroes, thus showing that the negro cases represent 9.55 per cent. This is quite sufficient to disprove the idea of immunity which the negro is supposed to enjoy.

Geographically, the cases were distributed as follows: Alabama, 10; Arkansas, 11; Florida, 28; Georgia, 90; Kentucky, 56; Louisiana, 19; Mississippi, 99; North Carolina, 126; South Carolina, 66; Tennessee, 128; Texas, 98; Virginia, 430. Of those in which the sex is indicated there were 691 in males and 97 in females. There were 182 cases not subjected to operation, and 584 in which the stones were removed by the following methods: Lateral perineal, 249; medial perineal, 100; suprapubic, 138; vaginal incision, 32; dilatation of female urethra, 28; crushing, 35; and operation not given, 5. Of those operated on, 541 recovered and 43 died. No report of operation was given in 304 cases. Dr. Johnston's own cases are incorporated in the foregoing statistics. During his twenty years' practice he has made notes in 41 cases,—the third largest list furnished by any reporter; and what seemed to him the enormous number of cases in the negro, in the face of its supposed rarity, caused him to set on foot the inquiries leading up to this paper. Of his 41 cases there were 35 in whites, 6 in blacks; 39 in males and 2 in females. Thirty-nine were operated on and 2 were refused operation on account of advanced kidney disease; both died. In 25 cases lateral perineal lithotomy was done, in 12 suprapubic, and in the cases of the 2 females the urethra was dilated and fragmentation practiced. He had no deaths following operation. — *Medical Record*, November 30, 1895.

The Buried Tendon Suture.—Dr. H. O. Marcy, of Boston, who was the first to suggest and employ the buried suture, in 1870, in a paper on the subject stated that the defect of catgut is inherent in its structure, and that it cannot be rendered satisfactory by any method of preparation. "The connective-tissue sheath of the intestine of the sheep from which catgut is manufactured has its ultimate fibres disposed in an oblique direction crossing diagonally. This serves the physiological purpose of foreshortening and distension as well as strength." The violin-string (catgut of commerce) is not unlike a very thin piece of tissue-silk which has been cut diagonally and then twisted. This would make a very imperfect fish-line, and the comparison is not overdrawn. When dry, the gut is strong; but when wet, it is flat, elastic, and slippery. Chromicizing only partially remedies this defect, and sterilization by any process cannot correct the damage which the intercellular cement-substance has sustained from bacterial infection and the maceration to which, in preparation, the catgut is necessarily subjected. Properly-prepared tendon not only escapes these injuries, but has an entirely different ultimate structure. The connective-tissue cells are disposed parallel to each other and are the strongest structures of the animal economy. Of equal weight, carefully-selected tendon will sustain a tension equal to that of silver wire. Tendons taken from the freshly-killed animal are quickly sun-dried and kept dry until their final preparation. Soaked in a 1 to 1000 mercuric solution until supple, the tendons are carefully cleansed, assorted, and dried between sterilized towels. They are then chromicized until of a dark golden-yellow color, and preserved in sterilized linseed-oil to which one-tenth part of the crystals of carbolic acid has been added. Sutures thus prepared improve with age. When desired for use they are soaked in a 1 to 1000 solution of bichloride of mercury until supple. Preservation in absolute alcohol, boiling in it under pressure, boiling in kumol (oil of caraway-seed),—indeed, preparation by any of the methods suggested for the sterilization of catgut,—serve only to injure the inherent structure of tendon and are not to be commended.

The tendons from the tail of the smaller varieties of the kangaroo furnish by far the most valuable suture material yet found. The anatomical construction of the psoas muscles of the rat, squirrel, and the opossum is not unlike that of the kangaroo, each fasciculus having its independent tendon extending the entire length of the tail. The tendons of these smaller animals are too short and too fine for general use, those from the large kangaroo too large. The latter when subdivided fray and are less valuable.

Dr. Marcy expressed the belief that all aseptic wounds, including even the larger amputations, should be closed in layers by buried tendon sutures without drainage. The edges of the skin should be coapted by means of a parallel continuous buried suture (subcuticular), and the wound sealed with iodoform collodion and strengthened by a few fibres of cotton. The advantages of the buried sutures are, briefly, as follow: Aseptic, buried in aseptic wounds, they remain aseptic, and the repair is primary without inflammation, pain, or suppuration. The iodoform-collodion seal renders subsequent infection impossible. No sutures are to be removed, and no other dressing is required. The tendon is absorbed so slowly that it may be traced in the tissues months after implantation, and ultimately it is replaced by a band of vitalized connective tissue, which serves as a permanent re-enforcement of the united structures.

NEW YORK STATE MEDICAL ASSOCIATION.

A New and Original Method for Obtaining Material for Skin-Grafting.—DR. ZERA J. LUSK, of Warsaw, N. Y. (*Medical Record*, December 7, 1895), has found that the epidermis raised by vesication could be successfully employed in skin-grafting, the cutis being separated from the cuticle, thus forming an ideal material. He described the case of a workman who had fallen into a pan of boiling brine, head foremost. In attempting to remove him he again fell into the pan, and when rescued it was found that more than two-thirds of the surface of his body had been burned. There were profound constitutional symptoms, and his condition was considered hopeless. A month after the accident, however, favorable symptoms appeared, and Dr. Lusk thought he might possibly get well, though he was extremely emaciated, and nearly one-fourth of his body was a raw, granulating surface. As no one would consent to furnish strips of skin, it was impossible to utilize the Thiersch method. An idea was then suggested by the following condition: There were numerous patches of exfoliated epithelium, the remains of vesication. They were hard, dry, and crisp, having for nearly five weeks been separated from the cutis. Why could not this material be utilized for skin-grafting? Dr. Lusk had faith to believe that it could, and therefore made grafts, using the following material: Attached to the dorsum of the right foot by one edge, the other being free and raised one-fourth inch, was a patch of dry, exfoliated epithelium, extending nearly across over the surface, near the distal end of the metatarsal bones; the floating part was from one to one and one-half inches wide. From this he clipped off a piece one inch square, softened and sterilized it in warm boric-acid water, and divided it into twelve grafts, which were applied to the anterior granulating surface of left thigh. The result was eminently satisfactory. Seven out of the twelve grafts took, and rapidly developed into vigorous islands of skin. The subsequent treatment consisted in using this dried. epithelial tissue, with which these large raw surfaces were covered with substantial skin by April 1st, five months after the accident.

The man began sitting up a few days prior to this date, and with the attendant's aid could walk about the room. A month later the following experiments were made in the presence of an assistant and others: A little to the right and two inches below the trochanter major of the left leg, there was a raw surface three and one-half inches in diameter. At the proximal end of the great toe there was a dry, bleached patch of epithelium which had been thoroughly isolated from the body seven weeks, being held only by ends of hair. With this material this raw surface was completely healed in twenty-one days. The man recovered with perfect use of the joints and the entire absence of cicatricial contraction.

Dr. Lusk also described a case in which he produced a blister and used the epithelium as a grafting material. The patient was a woman, aged 52 years, who had a large varicose ulcer two and one-half inches in diameter, three inches above the ankle on the outer surface of the left leg. She had worn elastic hose and tried all kinds of ointments for eight years. The granulations were unhealthy and bathed with a foul-smelling discharge. The treatment consisted first in thorough curettement, followed by stimulating applications, so that in ten days the granulations appeared healthy. A surface on the left thigh near the anterior superior spinous process was made aseptic, and on it was applied a piece of emplastrum cantharides two inches long by one inch wide (first moistened with carbolized oil). Vesication was produced in six hours, when the plaster was carefully removed. The epithelium was detached at the edges of the blister, washed in boric-acid solution, after which all moisture was absorbed with sterilized cotton, and it was suspended in a four-ounce salt mouth-bottle (aseptic cotton being used for a stopper), and kept at a temperature between 55° and 70° F. (12.8° and 21.1° C.). It was thoroughly dry in three days, when a piece one inch square was divided, making twelve grafts, which were applied in the usual way. The results were extremely gratifying. Nine of the twelve grafts took nicely and grew rapidly, so that in one month this ulcerated surface was healed, having a substantial epithelial covering.

TRI-STATE MEDICAL SOCIETY OF ALABAMA, GEORGIA, AND TENNESSEE. CHATTANOOGA.

Tuberculosis.—DR. R. M. CUNNINGHAM, in his presidential address on this subject, based on observations made in the Alabama penitentiary, stated that of an equal number of white and negro convicts there were seven deaths among the latter to one among the former from tuberculosis. These figures demonstrate the wonderful racial predisposition of the negro race to tuberculosis, compared to the white under precisely the same environment. He expressed the opinion that the negro has acquired since his emancipation a predisposition to tuberculosis which, for the present and succeeding generations, is hereditary. He shows a greater liability to diseases which produce a local predisposition to tuberculosis, notably bronchial and intestinal catarrh and pleurisy. He is physically, mentally, and morally inferior to the white man, and therefore more liable to contract disease, particularly tuberculosis and thoracic diseases. His changed social, religious, political, and industrial relations, involving, as a rule, a change from the segregate to the aggregate,—from country to town and from farm to public works,—are also important factors, as well as his disregard for all rules of sanitation. —*Southern Medical Record*, December, 1895.

AMERICAN LARYNGOLOGICAL ASSOCIATION.

The Cigarette Habit.—DR. J. C. MULHALL, of St. Louis, himself a cigarette smoker for twenty-five years, disperses the popular delusion that when the smoke of a cigarette is "inhaled" it pervades the air-vesicles of the lungs and the nicotine it contains is all absorbed into the blood through the delicate respiratory membrane. As a matter of fact, the smoke reaches only to the larger bronchial tubes, probably in a majority of instances not to a point much below the larynx. To the mucous membrane of these large air-passages the smoke does little harm as an irritant, although it may aggravate pathological conditions already present. The surface by which nicotine is absorbed into the blood is much larger than that of the mouth, however; so that, although relatively only a little of the poison is contained in a cigarette, much more of it finds its way into the system than when the smoke from a cigar or a pipe is simply drawn into the mouth and at once blown out. The inference to be drawn from this is that the inhalation of tobacco-smoke is a bad practice. That it is more likely to be indulged in by persons who smoke cigarettes than by those who restrict themselves to cigars and the pipe may be readily conceded. At the same time it is quite certain that many smokers inhale cigar-smoke and pipe-smoke at times, if not habitually; sometimes they do it involuntarily. Dr. Mulhall expresses himself against the common assumption that cigarettes are especially injurious on account of their containing other poisons besides nicotine. So far as the constitutional effects of cigarette-smoking are concerned, he states, as the result of fifteen years of careful study of the matter, that they are absolutely the same as those of tobacco used in any other form, and he cites Ledaux, who has subjected various brands of cigarettes to chemical analysis, as having found absolutely no evidence of any other drug but nicotine in the tobacco, and in the paper a harmless quantity of cellulose. It is, indeed, the height of absurdity to suppose that cigarettes are sophisticated with opium. Opium, as has been often said, is too expensive to be used for such a purpose. The chief evil of tobacco is its constitutional effect upon the nervous system; and, as the cigarette-habit is so common in boys, it is to be deplored on that account; but as far as its local effects on the larynx are concerned, the author has been unable to discover any but trivial hyperæmia and secretion.—*New York Medical Journal*, November 30, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Poland.

DR. J. DRZEWIECKI,

Redaktor Korespondent z działu polskiej literatury tyczącej się: Medycyny ogólnej i lecznictwa; pediatryi; akuszerzyi; ginekologii; laryngologii; otologii; hygieny; demografii; medycyny sądowej; histologii; patologii; bakteryjologii; anatomii; fizjologii.

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w języku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

DRA. DRZEWIECKIEGO,
87, Krakowskie Przedmieście,
Warszawa,
Królestwo Polskie.

Effects of Antiseptics on the Gonococcus.—W. REISS has examined the action of various antiseptics upon the growth of cultures of Neisser's diplococcus and has come to the conclusion that these cultures, by repeated inoculations, become more and more accustomed to the new culture-medium and show greater resistance to antiseptics, dying only when treated by gradually-strengthened antiseptics or when every new generation is treated with a new drug. He has observed the effect of corrosive sublimate (1 to 10,000, 1 to 1000, 1 to 500), nitrate of silver (1 to 2000, 1 to 1000, 1 to 100), carbolic acid, resorcin, sulphate of zinc, permanganate of potassium, sulphate of copper, etc. The surface of the culture-medium (agar and serum) was covered with a thin layer of the examined solution, the surplus poured off, and inoculations of gonococcus made. His experiments would indicate that in gonorrhœa the antiseptic solutions injected must be of increasing strength and changed from time to time.—*Przeglad lekarskie*, Nos. 26, 27, 28, 1895.

Examination of the Urine for Sugar.—LUXENBOURG describes a case showing how important it is to note the time of day as well as the conditions under which urine is taken for examination. A boy of 16 years had had for the previous eight months an increase in the quantity of his urine, as well as appetite and thirst, and, at the same time, general debility. Examination of the daily quantity was made, and the specific gravity found to be 1034, with 6.1 per cent. of sugar. Milk diet was prescribed. On the morning of the third day afterward, on an empty stomach, his urine was discharged in the presence of the author, was found to be 1011 specific gravity, and contained no sugar. The same was the case at noon, four hours after taking a glass of milk; but at 2 o'clock the urine again contained sugar, which disappeared entirely at 7.30 P.M. Further observation showed that the sugar was constantly present in the morning urine and absent in the evening. Mistakes may thus arise from the examination of only portions of the urine, and not that of the whole day.—*Gazeta lekarska*, No. 38, 1895.

Four Cases of Glioma of the Retina in One Family.—FEINSTEIN describes the following cases: Twenty years ago a boy 2 years old was operated on for a neoplasm in the eye, and some months afterward fatal relapse occurred. Two years later enucleation of an eye was performed on his sister for the same kind of growth, the patient being still living. A second sister, 7 years of age, was operated on four years ago, but died three months after from relapse of the growth. Last year a brother of these patients brought his 4-year-old daughter for examination, when it was found that she also suffered from glioma, enucleation being necessary.—*Gazeta lekarska*, May 4, 1895.

Russia.

DR. J. DRZEWIECKI,

РЕДАКТОР-КОРРЕСПОНДЕНТ

из области русской литературы, касающейся: Общей медицины и терапiи, педiатрiи, акушерства, гинекологiи, ларингологiи, отологiи, гигiены, демографiи, судебной медицины, гистологiи, бактерiологiи, анатомiи и физiологiи.

Всѣ периодическiя, медицинскiя изданiя, сочиненiя, статьи, монографiи и т. д., изданныя на русскомъ языкѣ и касающiяся вышепоименованныхъ предметовъ должны быть адресованы на имя

ДРА ДРЖЕВЕЦКАГО.

87 Краковское Предмѣстье,
Варшава.

Changes in the Nerves in Spontaneous Sphacelus.—The very scanty knowledge on this subject induced W. W. MURAVIEFF to undertake a series of examinations, using the crural nerves for the purpose. After hardening them in chromic acid and alcohol he cut diametric sections and stained them with carmine, picrocarmine, and nigrosine, according to the methods of Van Giesen and Pal. The typical picture of all the preparations showed the following peculiarities: Connective tissue of the nerve was much thickened and surrounded by large rings, the roundish nerve-bundles being pressed and wrinkled; in the external part of this membrane, arteries a little larger, with greatly-thickened walls (at the expense of the intima), were seen, as well as irregular lumina in the shape of fissures; some of the vessels were entirely obliterated, with signs of general sclerosis; small arteries were seen in great quantities, but in an inflammatory state, as were also the veins, though in a less degree. The thinness of the nerve-fibres was noticeable, as well as the loss of myelin, and in some places the disappearance of cylinder-axis.

Spontaneous sphacelus of the extremities may, according to this author, be summed up as (1) an inflammation of the arteries, especially of their intima (endarteritis), and (2) sclerosis of the nerves, in which the affection of the arteries may be regarded as a primary process, so accepted by the majority of writers who have investigated this subject.—*Meditzinskoje Obozrenije*, No. 16, 1895.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM
FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

Diagnosis of Diphtheria.—THURE HELLSTRÖM (*Hygiea*, vol. lvii, No. 9) maintains that the clinical picture of a pharyngeal affection does not, in the majority of cases, permit of establishing a positive diagnosis, but that bacteriological examination may be relied on. Of 1881 patients admitted to the new epidemic hospital at Stockholm, from September, 1893, to August, 1895, with diphtheria or suspected diphtheria, the Löffler bacillus was present in 1304 (69.32 per cent.), while 577 (30.68 per cent.) were free from it. In consequence of this the authorities omitted every measure of disinfection in the latter cases. In order to establish an absolutely certain diagnosis, Hellström made cultivations upon unmixed ox-serum,—a simple and speedy method. He states that the presence of very small cocci is a good prognosis, while streptococci with diphtheria bacilli make the prognosis worse. Hellström claims to have proved that the long and slender bacilli are the real cause of true diphtheria, while the short and thick ones are of subordinate importance.

Of 664 scarlatinal patients examined, the Löffler bacillus could be detected in only 13 (1.95 per cent.). Convalescents, however, in whom the bacillus appears in later stages are dangerous, as true diphtheria contagion can be disseminated by them. Hellström never found the diphtheria bacilli to be a cause of phlegmonous angina. In the majority of cases of croup diphtheritic infection is the real cause, but cases of croup occur which are not engendered by the Löffler bacillus, but by cocci which, though infectious, warrant a favorable prognosis. In 17 cases of scarlet fever with croup in the later stages, and in numerous cases of measles with croup, diphtheritic origin was demonstrated in all but two cases, where only cocci could be implicated. The author mentions that, out of 15 tracheotomies for scarlatinous croup, 11 died, and, in 31 tracheotomies for croup after measles, 28 died.

The presence of the Löffler bacillus in the throat of apparently healthy persons, who become immediately affected by true diphtheria, seems to prove that they are the real originators of the disease, and the author mentions several examples in which such seemingly healthy persons spread the contagion. From a great many observations he maintains that it is not the rule that in the lighter cases the bacilli pass away more rapidly than in the severer ones, but, on the contrary, bacilli surviving a long time after uncommonly light cases have shown a permanent virulence. It is also undoubted that in the severer cases the mucous membrane of the throat sooner ceases to be a fruitful field for their growth.

Antitoxin Treatment of Diphtheria.—The same author (*Hygiea*, vol. lvii, No. 10) reports the result of the treatment of 358 cases of diphtheria in the new hospital at Stockholm, from February 1, to August 1, 1895, in 164 of which antitoxin was used. Of the total number, 209 cases occurred in children under 10 years of age, of which 7 died (1.96 per cent. mortality). There were 52 cases of croup, 31 of which, all under 10 years, were tracheotomized, with 3 deaths. The other 4 deaths occurred during the first forty-eight hours in hospital, and, if these be deducted, the mortality is 0.85 per cent. of the whole number and 1.46 per cent. among those below 10 years. Of those treated with serum, albumin appeared in 66 cases (31.57 per cent.); and, among 142 not so treated, traces were observed in 11 and larger quantities in 17 cases.

Hellström believes that well-prepared and well-preserved serum does not affect the kidneys, and that such disorders during serum treatment must be ascribed to the influence of the diphtheritic virus. The paralysis so often observed during and after diphtheria is neither less frequent nor changed in character under the serum treatment. In 2 of the cases mentioned the carbolic acid employed in the preparation of the serum was, perhaps, the cause of death.

Clinical Notes.

A Case of Phthisis Apparently Cured.—Prof. William Pepper, of Philadelphia, describes, in the December number of the *University Medical Magazine*, a case seen by him, in consultation with Dr. W. Duffield Robinson, in which pulmonary tuberculosis was apparently cured. The patient was a woman of 21 years, whose family history revealed a decided taint of tuberculosis, her mother and several other members of both sides of the family having died of phthisis. Her mother died in the spring of 1892.

In March, 1893, the patient suddenly began to lose flesh, her appetite became poor, her digestion much deranged, cough and expectoration appeared, and general debility followed so rapidly and overwhelmingly that, when first seen, during the latter half of the month, she was already bedridden. At that time her condition and the physical signs were as follow: She was extremely emaciated, weighing but 100 pounds (44.4 kilogrammes). Fever was constant, very irregular, and with a high evening rise. She suffered nightly from the most profuse and exhausting sweats.

Her appetite was entirely abolished; the stomach was so irritable that the slightest cause would provoke violent attacks of vomiting. Cough was persistent and the expectoration very free; the daily average was 8 fluidounces (250 cubic centimetres) of thick, tenacious, heavy sputum. In the right apex and over the base of the left lung were signs of consolidation,—increased fremitus, dullness on percussion, bronchial breathing, with fine crackling râles and a few bubbling râles. The sputum contained myriads of tubercle bacilli; the bacteriologist regarded the abundance of bacilli as the most extreme in his experience; hundreds could be counted in one field. An unfavorable prognosis was, of course, the only one that seemed justifiable.

The patient was placed upon a diet of egg-albumen, which seemed to agree with her stomach better than any other food; and this diet was forced so that she consumed daily the albumen of two dozen eggs. The medicinal treatment consisted of $\frac{1}{100}$ grain (0.00065 gramme) of strychnine nitrate with $\frac{1}{1000}$ grain (0.000065 gramme) of atropine sulphate every two hours hypodermatically, and $\frac{1}{50}$ grain (0.0013 gramme) of strychnine nitrate with $\frac{1}{12}$ grain (0.005 gramme) of the double chloride of gold and sodium and $\frac{1}{2}$ grain (0.03 gramme) of a vegetable digestive every two hours by mouth. After a few days the amount of gold and sodium was increased to $\frac{1}{8}$ grain (0.008 gramme) every two hours. She was given codliver-oil inunctions, and general massage with passive movements once daily. At first she showed signs of strychnine intoxication, and the dose was reduced, but she soon assumed the original dose, and after the first two weeks she bore the drug well, although always just inside the border-line of its toxic action. During April she improved decidedly; she regained flesh, the fever became less marked, the night-sweats less profuse, the cough was allayed, and the expectoration much reduced, though still rich in bacilli. During May the improvement was very rapid. By the latter part of the month she had recovered her normal weight,—125 pounds (56.8 kilogrammes). The fever and night-sweats had disappeared, the appetite was good and the digestion normal, the cough was almost gone, and tubercle bacilli had disappeared from the sputum, which was still expectorated in very slight amount. All signs of consolidation in the right apex and base of the left lung had disappeared; the only remaining sign was slightly-harsh breathing at those sites. She was instructed to continue her general treatment, to return to a normal diet, to practice forced, deep breathing and graduated exercises, and was sent to the mountains. In September she returned to the city in perfect health. Her weight was 132 pounds (60 kilogrammes); she was robust and muscular, with better chest-expansion than she had ever possessed before in her life. There was no cough or expectoration; the lungs were in all respects entirely normal, except for a patch of emphysematous breathing in the base of the left lung. She re-entered upon her social duties and has since led a busy life. Her health continued perfect until early in August, 1895, when she had a slight attack of pneumonia involving the base of the left lung. The sputum was sparse, resembled prune-juice, and was crowded with pneumococci and tubercle bacilli.

The attack ended by crisis on the eighth day, and a few days later she was again sent to the mountains. She returned in ten days with a recurrence of all the symptoms of the attack of two years previous. Her weight had fallen to 114 pounds (50 2 kilogrammes); there were anorexia, fever, cough, and free expectoration, which was full of tubercle bacilli. In the base of the left lung was consolidation with moist râles. She was placed on the same treatment given her during the first attack, and she rapidly regained flesh and strength. On November 1 her weight was again up to 124 pounds (56.4 kilogrammes), all fever was gone, and the cough and expectoration had almost disappeared. Tubercle bacilli were not to be found since the last week in October. The consolidation had become greatly reduced, but was still present when, a few days later, she was again sent to the mountains.

The points of interest in the case are: the sudden onset, quite like general miliary tuberculosis; the large number of bacilli; the rapid recovery, all the more remarkable with a pronounced tubercular family history; the complete disappearance of consolidation and bacilli; the acute reappearance after two years of the whole train of symptoms, with signs in the base of the left lung directly following an attack of pneumonia located in that vulnerable part; the large number of bacilli and their early complete disappearance in the second attack; the abatement of the consolidating process, and rapid recovery of the general health after the second attack; the absence from the treatment of all cough-medication and antiseptics, and the large doses of strychnine nitrate and the double chloride of gold and sodium, with which the system was kept literally saturated.

Insanity and Pelvic Disease in Women.—DR. GEORGE H. ROHÉ, of the Maryland Hospital for the Insane, in a paper on operations in insanity, states that there seems still a wide-spread prejudice against examining the pelvic organs of insane women to determine the presence or absence of local diseases in the genital organs and pelvic viscera. The failure to make such examination, systematically, is doubtless responsible for the opinion, current among asylum physicians, that pelvic disease is rare among female lunatics. Systematic examination of the pelvic organs by one familiar with modern methods would disclose a large proportion of pelvic disease among female lunatics. His own examinations in the Maryland Hospital have shown that fully 60 per cent. of the women admitted have some lesion of the genital organs or pelvic viscera. Many of these are of so slight a character as to require no treatment, but others can only be relieved by some form of operative interference. The affections frequently found are rupture of the perineum, abscesses, cysts of the vulvo-vaginal gland, lacerated cervix uteri, catarrhal and purulent endometritis (usually following puerperal septic conditions), cancer of the uterus, fibroid tumors of the uterus, salpingitis and ovaritis, pyosalpinx and ovarian abscess, cysts of the ovaries and of the broad ligament, and pelvic peritonitis. Defective development of the external genitals has often been found in the class rather vaguely termed "degenerates." In a certain proportion of cases the diagnosis of masturbation can also be made with certainty by physical examination.

The mere co-existence of pelvic disease and insanity in women does not, however, establish a causative relationship. The cure of the mental disturbance by removing the physical disease would generally be accepted as a sufficient test. Unfortunately, a cure of the mental derangement does not always follow removal of the local disease. There are abundant reasons for this. The brain-organization may have already been so much deteriorated by the persistent reflex irritation from the local disease that local cure fails to restore the normal brain-power. The habit of morbid action of the brain may have been so strongly impressed upon that organ that the original cause of the derangement is no longer necessary to keep it up.

During the past four years Dr. Rohé has examined 100 women, in 40 of whom he found local lesions sufficient to justify operation. In 30 of these abdominal section with removal of the uterine appendages was practiced. In 2 of these a subsequent abdominal section was done for the relief of distressing local symptoms. In 1 peritoneal adhesions were separated, and in the other a small hæmatoma was found in the stump of one of the tubes. In 3 of the 30 cases a secondary vaginal hysterectomy was done; 2 of these had already been subjected to a second laparotomy; 1 of these was finally cured both of the local symptoms and the mental disturbance; 2 cases were subjected to primary vaginal total extirpation of the uterus and appendages. In 2 repair of lacerated cervix was done. In 6 the guardians of the patients would not consent to operation. Of the 30 abdominal sections there were cured, physically and mentally, 10; decidedly improved, 4; unimproved, 13; died, 3. Of the 3 secondary vaginal hysterectomies, which are included among the 13 unimproved after removal of appendages, 1 was cured and 2 remain as before. Of the 2 primary total extirpations 1 was cured and the other so much improved as to give strong hope of ultimate mental recovery. The 2 trachelorrhaphies both recovered, mentally and physically.

The final results of the operations at present are, therefore: cured (physically and mentally), 14; improved, 5; unimproved, 12; died, 3. Total, 34. The clinical variety of mental disturbance in the recovered cases was: puerperal insanity (mania), 4; melancholia, 6; mania, 3; hystero-epilepsy, 1. Total, 14. In the cases in which complete recovery did not follow the operative measures there were, of melancholia, 2: mania, 5; puerperal insanity (mania), 1; dementia (including 4 epilepsies), 7 (3 deaths); paranoia, 2; hysterical insanity, 2; adolescent insanity, 1. Total, 20.

The number of cases is too small to allow of definite conclusions, but if anything of practical value can be deduced from them it is that puerperal insanity (melancholia and simple mania) offers the best chance of cure from the proper treatment of local lesions in the pelvis. Of course, it may be said that these forms of mental disorder are just those which yield in the majority of cases to the usual methods of management of insanity. In 7 of the cases, however, the insanity had lasted over eighteen months before any treatment directed to the local lesion had been instituted. In a case of hystero-epilepsy the patient had been in the hospital seven years, and 1 of the cases of puerperal insanity had been four and a half years insane. The author is convinced that earlier operation in appropriate cases would very largely increase the proportion of recoveries. He does not claim that the results prove that insanity is caused by pelvic disease, but they do show that judicious treatment directed to the physical disease benefits the patient's mental condition.—*Journal of the American Medical Association*, October 12, 1895.

Streptococcous Enteritis.—There are, according to EGUET and DE CÉRENVILLE, of Geneva (*Annales Suisses des Sciences Méd.*, vol. ii, No. 11, 1895), two distinct forms of streptococcous enteritis,—the acute and the typhoid forms. Of the acute there are three varieties: one, sudden and intense, choleriform, and limited to the digestive tube; the second, complicated by peritonitis; the third, a generalized form, engendering the syndroma of acute septic pyæmia. The differential diagnosis between choleriform enteritis and cholera is difficult and can only be made by means of a bacteriological examination; while, on the other hand, it is easy to differentiate between cholera from the pyosepticæmic variety, since the latter is accompanied with great fever and tumefaction of the spleen,—symptoms absent in cholera; in addition, no muscular cramps are observed, but symptoms of peritonitis often develop with great rapidity. The prognosis of streptococcous enteritis is grave; of 8 cases observed, 7 proved fatal. Of 4 cases of the typhoid form observed by de Cérenville, coming on after the ingestion of suspected food, and in 1 case after the use of the thermo-cautery in the treatment of hypertrophied tonsils, the prognosis was better, all the patients recovering. This form may be distinguished from typhoid fever by its sudden onset, shorter period of incubation, and the presence, from the beginning, of a fetid diarrhœa resisting all medication. The tongue may remain clear for a long time; bronchitis is uncommon or but light in form; the spleen is not so hypertrophied as in typhoid fever; the exanthema is not so characteristic or may be entirely absent; the central nervous system is not involved; and the fever affects an intermittent type. The point which differentiates it most clearly from typhoid fever is its tendency to acute localization in the peritoneum, lungs, or pericardium. In a case seen by the author there was a severe pain in the right flank after the second day, increasing rapidly until a peritonitis of cæcal origin seemed imminent; these symptoms then rapidly disappeared, but next day a pleuropneumonic area was noted at the base of the right lung, with all the appearances of pneumonia of embolic origin, and dry pericarditis. These new symptoms disappeared in their turn. In another case there was also an attack of dry pericarditis, and on the fifth day an abundant intestinal hæmorrhage. The treatment employed by de Cérenville in the typhoid form consisted of baths gradually lowered in temperature, quinine, naphthol, digitalis, and hypodermatic injections of strychnine.

Syphilitic Peritonitis.—LANCEREAUX was the first to call attention to the peritoneal localization of syphilis; this localization is, however, rare, and occurs especially in the tertiary period; so that a case observed by KROUPEZKY, of Dorpat (*Wiener med. Blätter*, October 3, 1895), in the secondary stage, is of especial interest. A robust, healthy man, of 61 years, became infected with syphilis, and six weeks later presented himself with all the secondary signs of the disease,—papular eruption, mucous patches, etc. Specific treatment led to their disappearance, but constipation supervened, at first temporary, but becoming more marked and rebellious against all efforts to relieve it. At the same time the abdomen increased in size, the appetite failed, and signs of intestinal obstruction appeared, but there was no pain and no physical or functional indication of peritonitis. The patient died from slow stercoral infection, and at the necropsy the peritoneal cavity was found to be filled with false membranes, which had caused agglutination of the intestinal loops, the colon being adherent to the intestinal wall and the sigmoid flexure so bound down by adhesions as to cause stenosis. The other organs were but little changed. It thus appears from this case that syphilitic peritonitis may appear in the secondary stage after the eruption, that it is painless, and may pass unobserved.

Suprahepatic Peritonitis.—PROFESSOR POTAIN (*Bull. Méd.*, November 13, 1895) discusses the diagnosis of suprahepatic peritonitis, an affection generally due to perforation of the stomach or intestine. Investigation will nearly always reveal some previous disturbance of the digestive or biliary passages, more or less serious in character. When such a peritonitis has declared itself, the most important sign is the suppression of spontaneous movements of the diaphragm, the muscular rôle of which is abolished. When the effusion has reached a certain size, the liver falls somewhat, and puncture in the suprahepatic region gives exit to pus. The influence of respiratory movements on the flow of the fluid may be observed during this operation; during expiration it issues freely through the trocar, while during inspiration it ceases to flow. This is exactly the reverse of what occurs when aspiration is performed for purulent pleurisy. When the effusion consists not only of liquid, but also of gaseous elements, tympanites is present, and this may be distinguished from the sonorous pulmonary sound to which it succeeds by percussion from above downward. It is an abdominal pneumatosis due to intra-peritoneal gaseous effusion in the suprahepatic region, and differentiated from pneumothorax in many ways, particularly by the existence of pulmonary sonorousness above the tympanitic region, easily recognized by its lower timbre; in pneumothorax this is absent, from the fact that the lung is compressed. By changing the position of the patient the displacement of fluid can easily be ascertained, as in pyopneumothorax. Suprahepatic peritonitis sometimes remains latent and gives rise to secondary accidents. The treatment is purely surgical.

Compression of the Duodenum.—The symptoms resulting from compression of the duodenum are discussed by A. BROU (*Proceedings of Royal Society of Edinburgh* for 1895), according to whom displaced organs, neighboring tumors, or peritoneal adhesions may cause such pressure upon the duodenum as to give rise to temporary or permanent signs of obstruction. This obstruction, if complete and left to itself, ends fatally. There are two prominent symptoms of the condition,—vomiting, almost always incoercible and bilious, and alternating constipation and diarrhœa.

The stomach is also the seat of dilatation more or less severe. These signs will aid in the diagnosis, but only surgical intervention can verify it, and usually this becomes necessary.

Significance of Vaginal Discharges. — A leucorrhœa inodorous or of mild odor, persisting during the climacteric, accompanied by increasing hæmorrhage, is suspicious and demands investigation.

A leucorrhœa profuse, of peculiarly fetid odor, grumous, excoriating, appearing early or late during the climacteric, with profuse hæmorrhage, is reasonable evidence of cancer of the cervix.

A leucorrhœa moderate in amount, ill-smelling (the peculiarly fetid odor of cancer of the cervix being absent), accompanied by hæmorrhage, suggests cancer of the corpus uteri.

A leucorrhœal discharge with hæmorrhage, containing material like the washings of meat, is said to indicate sarcoma.

A watery discharge, as a rule, occurring during menstruation, odorless or of little odor, persisting, accompanied by profuse hæmorrhage, indicates fibroids; with little or no hæmorrhage, polypi.

Profuse bloody discharges coming on gradually with declining menstruation, ceasing usually with the menstrual flow, point to fibroids.

Persistent profuse discharges of blood occurring spontaneously, arising from sudden exercise or coition, occurring, as a rule, after the menopause, indicate cancer.—MISH, *Pacific Medical Journal*, November, 1895.

Pleuritic Effusion in Hepatic Cirrhosis. — The presence of pleuritic effusion on the right side only in Laënnec's atrophic cirrhosis has been noted as rather an exceptional symptom. G. VILLANI, however (*Riforma Medica*, March 9, 1895), is inclined to regard it as a constant symptom, having found it in nine cases of cirrhosis examined in Capazzi's clinic. He believes it to be of value in the diagnosis of doubtful cases in which it is difficult to determine whether ascites is due to cirrhosis of the liver, to thrombosis of the portal vein, or to compression of that vessel by tumors or swollen glands. In the latter conditions perihepatitis does not exist, while in atrophic cirrhosis its presence explains the pleurisy by propagation to the right pleura.

Recent Suggestions in Therapeutics.

Airol.—A green powder, consisting of *bismuth*, *gallic acid*, and *iodine*. Without taste or smell, and not soluble in alcohol, glycerin, or water. Recommended in leg-ulcers, especially when associated with eczema; in sycosis of upper lip, syphilitic sores and ulcers, small wounds, and mercurial stomatitis. (VEIEL, *Wien. klin. Rundschau*, October 20, 1895.)

Amygdophenin.—Derivative of *paramidophenol*. Grayish-white powder, slightly soluble in water. Recommended in articular rheumatism and neuralgia. Dose, from 1 to 6 grammes ($\frac{1}{4}$ to $1\frac{1}{2}$ drachms) daily: 5 grammes ($1\frac{1}{4}$ drachms) sometimes produces slight vertigo. (STUEVE, *Cent. f. inn. Med.*, November 16, 1895.)

Anæmia.—*Metallic iodine*, 0.25 gramme (4 grains); *potassium iodide*, q. s. to dissolve in *distilled water*, 20 grammes (5 fluidrachms). For hypodermatic injection into one buttock. Also, *ammoniacal ferric citrate*, 1 gramme (15½ grains); *distilled water*, 20 grammes (5 fluidrachms). For injection into other buttock. Dose, 1 Pravaz syringe daily or twice daily. (MENNELLA, *Semaine Méd.*, November 6, 1895.)

Burns in Children.—The following is the plan of treatment followed at the London Hospital: The child is wrapped in a blanket without being undressed, the blanket being secured around the neck and chest with safety-pins. The bed is moved before a fire, hot-water tins placed in it, and a screen placed behind it to protect from draughts and to reflect the heat upon it. To minimize shock from pain, *opium* is given at once, from 4 to 5 minims (0.26 to 0.32 gramme) of the tincture for a child of 2 or 3 years old, with about 2 drachms (8 grammes) of *brandy*. Should the child still be crying at the end of an hour, a further dose of 3 minims (0.20 gramme) is given. When the patient awakes the screen is drawn close, one burned part after another rapidly exposed and dressed with *zinc ointment* and *cotton-wool*, and the blanket once more wrapped around the body. The dressings are changed in four days, when suppuration commences, preparation for which has been made in the meantime by giving *tincture of opium*, in doses of 2 or 3 minims (0.14 or 0.20 gramme) every fourth hour, to induce sleep and prevent restlessness and friction, overdose being guarded against by never waking the child to give it its medicine. Thirty minims (2 grammes) of *brandy* are given every hour, with as much food as circumstances will allow after the first morning. When suppuration has set in, daily dressings, plenteous food, and *brandy* are relied on, with *opium* if there is much pain or restlessness. Diarrhœa is combated from its very inception with *bismuth carbonate*, 10 grains (0.65 gramme); *ipecacuanha wine*, 3 minims (0.20 gramme); *tincture of opium*, 3 minims (0.20 gramme); *mucilage* and *dill-water*, 2 drachms (8 grammes); every fourth hour. Aperients are never given for constipation, but enemata, as in measles. (HURRY FENWICK and H. L. BARNARD, *British Medical Journal*, December 7, 1895.)

Dysentery.—BENSE calls attention to a remedy employed by his *confrères* in the Dutch East Indies,—viz., *iodoform* injections, consisting usually of *iodoform*, 3 grammes (46 grains); *gum-syrup*, 200 grammes (6½ ounces). For three injections,—morning, noon, and night. As soon as the number of stools has diminished, the *iodoform* is discontinued, as it is no longer efficacious. (*Archives Méd. Belges*, October, 1895.)

Epistaxis.—With the patient seated in a stiff-back chair, insert one end of a small-sized, elastic-rubber tube, from two and one-half to three feet long, with a strong silk cord passing through its lumen into the bleeding nostril. When from three to five inches have been introduced, let the patient cough; continue to introduce tube until the distal end, with its contained cord, is extruded from the buccal cavity. Vomiting, although otherwise not desirable, would accomplish the same result as

Epistaxis (*continued*).

coughing. Secure a medicated-cotton tampon to the mouth end of the cord, and make gentle traction upon its nasal extremity, drawing the tampon to the position desired in the posterior nares. Then slip the rubber tube off the cord, which, with the pledget of cotton, will be left *in situ*. (J. T. PITKIN, *Buffalo Medical Journal*, December, 1895.)

Eudoxin.—A new bismuth compound of nosophen. A reddish-brown powder, without odor or taste, insoluble in water and unlike other bismuth salts, soluble in caustic alkalies; violet-blue in color. Recommended in gastric and intestinal disturbances. Dose, 12 to 18 grains (0.78 to 1.17 grammes), for adults, in three doses. (*Revue illust. de polytech. méd.*, October 31, 1895.)

Falsification of Codeine.—ETIÉVANT states that candied sugar may be used to adulterate codeine or as a substitute for it, the crystal being similar at first sight. Fehling's solution and the polarimeter will reveal the fraud, as the codeine deviates to the left, the sugar to the right. (*Repertoire de Pharm.*, November 10, 1895.)

Prophylaxis of Influenza.—GRAESER, of Vienna, believes that *quinine* is not only a specific in influenza, but that, if given at the proper time and in large-enough doses, it will prevent an outbreak of the disease. During an epidemic he administered the drug to soldiers in one of five squadrons in camp at Bonn, giving 0.5 gramme ($7\frac{3}{4}$ grains) daily for twenty-two days. Only 7 men in the squadron contracted influenza, 3 of these on the first day of the experiment; in the other four squadrons there were 22, 19, 32, and 42 cases, respectively. After the sixth day there were no more cases in the squadron taking *quinine*, while the disease continued among the members of the other squadrons. (*Wien. klin. Rundschau*, November 10, 1895.)

Pyelitis.—*Benzoic acid*, 0.20 gramme (3 grains); *theriaca*, 0.10 gramme ($1\frac{3}{4}$ grains). To make one pill; three or four pills daily. If the stomach rebel against *benzoic acid*, give *sodium benzoate*, 4 grammes (1 drachm); *raspberry-syrup*, 30 grammes (1 ounce); *linden-water*, 90 grammes (3 ounces). One tablespoonful in infusion of *buchu* three hours after meals. If there be pain: *Venetian turpentine*, 6 grammes ($1\frac{1}{2}$ drachms); finely-powdered *camphor*, 6 grammes ($1\frac{1}{2}$ drachms); *opium extract*, 0.25 gramme (4 grains); *extract of aconite-root*, 0.25 gramme (4 grains). To make sixty pills; one every eight hours, with an infusion of *uva ursi* sweetened slightly with *syrup of Canada balsam*. (ROBIN, *Traité de Thérapeutique appliquée*, Paris, 1895.)

Red-Light Treatment of Small-pox.—The exclusion of chemical rays must be absolute; even a brief exposure to daylight may produce suppuration. If glass is employed it must be of a deep-red color; if curtains, they must be very thick or in several layers, and nailed fast to insure carrying out the treatment correctly. Faint candle-light may be used during meals or during the visits of the physician. Other treatment which may be considered necessary may be carried out at the same time.

The red-light treatment should be commenced as early as possible; the nearer the commencement of suppuration, the smaller the chance of success. The patient must remain in the red light until the vesicles have dried up. (NIELS R. FINSEN, Copenhagen, *British Medical Journal*, December 7, 1895.)

Ringworm.—Common *salt*, applied in solution to scalp for five nights successively, washing off next morning with 10-per-cent. *boric-acid* soap. Cure in one month in three cases. (F. J. REILLY, *British Medical Journal*, November 23, 1895.)

Suppurating Bubo.—The following plan, a modification of Fontan's method, is employed by J. R. HAYDEN (*American Journal Medical Science*, November, 1895): 1. The field of operation is shaved and rendered surgically clean in the usual manner. 2. A few drops of a 4-per-cent. solution of *cocaine* are injected beneath the skin where the puncture is to be made. 3. A straight, sharp-pointed bistoury is then thrust well into the most prominent part of the swelling until pus flows. 4. All the pus is forced out through this opening by firm, but gentle, pressure. 5. The abscess-cavity is irrigated with pure *peroxide of hydrogen* until it returns perfectly clear. 6. It is then irrigated with 1 in 5000 *bichloride-of mercury* solution, all of which is carefully squeezed out. 7. The now thoroughly cleansed cavity is completely filled, but not painfully distended, with 10-per-cent. *iodoform ointment*, by means of an ordinary conical glass syringe, previously warmed in hot water. 8. A cold, wet, *bichloride* dressing is applied with a fairly-firm spica bandage, the cold congealing the ointment at the wound, and thus preventing its escape into the dressing. The patient should be kept very quiet for the first twenty-four to forty-eight hours, rest in bed being preferable, though not absolutely necessary. The dressing is removed at the end of the third or fourth day and the parts examined; if pus has re-accumulated or the ointment escaped into the dressing, a second injection may be made. If all look well, however, the first dressing is replaced by a gauze pad and spica bandage, and the patient is told to report himself in two or three days for examination. In fifteen cases treated in this way by the author, suppurative action and pain ceased after one injection of the *iodoform ointment* in all but two; in those the injection had to be repeated on account of a slight re-accumulation of pus. In order to get the best results from the method, it should be employed only when the glands are thoroughly broken down, so that the *iodoform* may come into direct contact with all the infected tissues.

Ulcers.—CHAUFFARD has, for five or six years, employed powdered sugar in dressing leg-ulcers, dusting the wound with it and covering with oiled silk, renewing the dressing every two or three days. Cicatrization takes place rapidly and aseptically. (*Bulletin Méd.*, December 1, 1895.)

A. SCHIRMAN applies commercial kerosene—from 33 to 50 per cent.—with alcohol, with a small camel's hair brush or gauze. Valuable for atonic or indolent ulcers. (*New York Medical Journal*, December 7, 1895.)

Varicocele.—Dr. J. Brault, of Lyons, has recently performed a new operation in two complicated cases of varicocele, having previously tested the method on the cadaver. (*Lyon Médical*, October 13, 1895.) He removes a large elliptical portion of skin from the external and posterior surface of the part of the scrotum involved, turning the flap upward and downward; he then exposes the large veins and resects them separately between two ligatures, closing the wound by approximating the flaps and stitching the margins together. He claims that this method is superior to that by which a part of the scrotum is removed through a transverse incision, while it can be rapidly performed and is accompanied by little hæmorrhage. The method is suitable for hydrocele combined with varicocele or with distension of the scrotum.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Bulletins et Mémoires de la Société Française d'Otologie, de Laryngologie, et de Rhinologie. Vol. x. Paris, 1895.——Transactions of the Royal Medical and Chirurgical Society of London. Vol. lxxviii. London, 1895.——Transactions of the Texas State Medical Association, Twenty-seventh Annual Session. Galveston, Texas, 1895.——Della Lussazione Isolata Posteriore del Cubito, pel **Dott Raffaele Minervini**, Naples, 1895.——Three Cases of Chronic Abscess of the Brain, by **J. T. Eskridge**, Denver, Col., 1895.——Sur les Troubles Laryngés dans la Syringomyélie, par **A. Cartaz**, Lyons, France, 1895.——Plea for a Methodically-Written Text-Book on Anatomy, by **Edmond Souchon**, New Orleans, La., 1895.——Surgical Treatment of Laryngeal Tuberculosis, by **J. W. Gleitsmann**, New York, 1895.——Contribution to the Study of Deaf-Mutism, by **Arthur Ames Bliss**, Philadelphia, 1895.——Hypnotism, by **William Lee Howard**, Baltimore, Md., 1895.——Treatment of Diphtheria with Antitoxin, by **Edwin Rosenthal**, Philadelphia, 1895.——Absorption and Metabolism in Obstruction of the Pancreatic Duct, by **Vaughn Harley**, London, 1895.——Guaiacol as an Antipyretic in Typhoid Fever, by **James Stratton Carpenter**, Pottsville, Pa., 1895.——Nine Reports of Surgical Cases, by **James T. Jelks**, St. Louis, Mo., 1895.——Pancreatic Diabetes in Animals and Man, by **Vaughn Harley**, London, 1895.——Sarcoma of the Nose, by **Norval H. Pierce**, Chicago, Ill., 1895.——Three Cases of Enucleation of the Eye, by **Leartus Connor**, Detroit, Mich.——Application of the Galvano-Cautery in the Nasal Passages, by **J. W Gleitsmann**, New York, 1895.——Traumatic Separation (Compound) of the Lower Epiphysis of the Femur, by **A. H. Meisenbach**, St. Louis, Mo., 1895.——Annual Report of the Ponasang Missionary Hospital, Foochow, China, 1895.——Non-Tuberculous Diseases of the Joints, by **Arthur J. Gillette**, St. Paul, Minn., 1895.——Epidemic Influenza, 1889 to 1895, by **Wm. Leland Stowell**, New York, 1895.——Influenza Complicating the Puerperium, by **R. Abrahams**, New York, 1895.——Paroxysmal Sneezing, by **W. Scott Renner**, Buffalo, N. Y., 1895.——Treatment of Uterine Retrodisplacements by Vaginal Fixation, by **F. H. Wiggin**, New York, 1895.——Chronic Progressive Chorea, by **W. F. Drewry**, Petersburg, Va., 1895.——Some Interesting Laryngeal Neoplasms, by **W. F. Chappell**, New York, 1895.——Indications for Laparotomy, by **W. O. Henry**, Omaha, Neb., 1895.——Aseptic Prophylaxis of Asiatic Cholera: Arsenization, by **R. B Leach**, Paris, Texas, 1895.——Tuberculosis of the Male Genito-Urinary Organs, by **J. T. Jelks**, Hot Springs, Ark.——Deaf-Mutes: Can they be Made to Hear? By **L. J. Lautenbach**, Philadelphia, 1895.——State Provision for Epileptics, by **W. F. Drewry**, Petersburg, Va., 1895.——Drilling Capillary Holes through the Skull for the Purpose of Exploring Brain, by **Edmond Souchon**, New Orleans, La., 1895.——Artificial Respiration, by **A. E. Roussel**, Philadelphia, 1895.——Case of Cardiocentesis, by **G. G. Cottam**, Rock Rapids, Ia., 1895.——Cœliotomy, by **Miles F. Porter**, Fort Wayne, Mich., 1895.——Laryngeal Papilloma, by **N. H. Pierce**, Chicago, Ill., 1895.——Treatment of Appendicitis, by **M. F. Porter**, Fort Wayne, Mich., 1895.——Surgical Treatment of Laryngeal Tuberculosis, by **J. W. Gleitsmann**, New York, 1895.——Direct Fixation in Fractures, by **B. M. Ricketts**, Cincinnati, Ohio, 1891.——When, Where, and How should the Surgeon Operate? By **W. O. Henry**, Omaha, Neb., 1895.——Two Fatal Cases of Sausage Poisoning, by **L. J. Mitchell** and **John A. Wesener**, Chicago, Ill., 1895.——New Methods Employed for the Relief of Impaired Hearing, by **L. J. Lautenbach**, Philadelphia, 1895.——Skiascopy and its Practical Application to the Study of Refraction, by **Edward Jackson**, Philadelphia, 1895.——Guide pour l'Examen Pratique de l'Urine, par le **Docteur James Tyson**, Philadelphia. Traduction de MM. **E. Gautrelet** et **A. S. Clarke**, Paris, 1895.——Transactions of the Ophthalmological Society of the United Kingdom. Vol. xv, London, 1895.

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(End of Editorial Department of Journal for January, 1896.)

"AN EXPLANATION CONCERNING THE PRELIMINARY COMMUNICATION ON CITROPHEN."

By Dr. R. Seifert.

Abstract from the *Deutsche medicinische Wochenschrift*, 1895, Nos. 32 and 14.

In his preliminary communication that appeared in No. 26 of the *Deutsche medicinische Wochenschrift*, Dr. Benario very evidently intends to claim priority for a medicament composed of phenetidin and citric acid. Such combinations, however, have been used for antipyretic and analgesic purposes in the Warsaw hospitals for many months past, and the results there obtained have been published *in extenso* by Dr. Leon von Nencki and Dr. Josef Jaworski in the *Gazeta lekarska* of May 27, 1895, and the following numbers.

There are various combinations of citric acid with phenetidin, all of which have been prepared by the chemical factory of Dr. F. von Heyden's successors. One molecule of citric acid can be combined with three molecules of phenetidin, giving us citrophen; but it can also be combined with two and with one molecule, giving us entirely different substances. Nencki and Jaworski have proved that the most useful of these combinations is that which contains the largest number of intact acid groups. This is Apolysin, which contains two complete citric-acid groups.

Apolysin is also the most freely soluble of the series. It dissolves in 55 parts of cold water and in less than 1 part of warm water. There are metallic salts of Apolysin; but it is the combinations with quinine, caffeine, etc., that deserve especial attention.

Apolysin has the following advantages over phenacetin and the other remedies of that group:—

1. It is very soluble, and hence more readily and completely absorbed. Its action is therefore quicker and surer.

2. There are no by-effects, even when large doses are given. The well-known cardiac-depressant effects of phenetidin, which are distinctly seen in phenacetin, are not to be found in Apolysin. This is probably due to the similarity of Apolysin to citric acid, and is in accordance with the law discovered by Prof. M. von Nencki (in the St. Petersburg Institute for Experimental Medicine), that the entrance of an acid group in a poisonous substance lessens or removes its poisonous properties. The chemical difference between Apolysin and phenacetin consists in just such entrance of acid groups.

In consequence of its non-poisonousness Apolysin can be given in large doses for the attainment of a marked and rapid antipyretic and analgesic effect without any danger of concomitant effects.

THE

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Selections from Society Proceedings.

AUSTRIA.

VIENNA MEDICAL CLUB.

Sexual Relations of the Thyroid Gland.—HERR FISCHER, in an interesting paper, stated that the relations between the thyroid gland and the female sexual organs have often been discussed since attention was directed to the fact that goitre predominated in women and that from 80 to 90 per cent. of the cases occurred in females. Myxœdema, moreover, is met with in women in 86 per cent. of the cases. The same thing is found in Graves's disease, and in respect of sclerodermatic processes the proportion as between women and men is three to one. Swelling of the thyroid gland has been observed in puberty and at the commencement of the menstrual period. Freund found an increase of this gland during pregnancy in forty-five out of fifty cases, and Wölfler has described a case in which during pregnancy the trachea became soft and the goitre increased. Goitres increase during delivery and decrease again some days afterward. Graves's disease also, if it develop during pregnancy, improves after delivery. It is doubtful whether the thyroid gland becomes larger during lactation, but in the climacteric period it undergoes atrophy. Goitre and phthisis seem to be incompatible, and phthisis is but rarely observed in the subjects of hypertrophied thyroid gland. Fischer then referred to the numerous theories as to the etiology of goitre. Morgagni supposed that there was a communication between the thyroid gland and the larynx, and he believed that the trachea is moistened by this gland, and that phonation is thereby facilitated. Some authors suggested that this gland was a regulator of the brain, whereas Freund considered that it was in connection with the genitals through the sanguineo-vascular system. In the lower animals extirpation of the thyroid gland causes atrophy of the sexual organs, which is due, according to Hofmeister, to shriveling of the ovarian follicles. Hens with hypertrophied thyroid glands also lay larger eggs than those which have atrophied thyroids. Post-mortem examination of a girl, aged 8 years, who was affected with myxœdema showed that both ovaries were of the size usual at 2 years of age and that they contained only a few follicles. The symptoms of Graves's disease depend in some degree on the condition of the patient's sexual development.—*Lancet*, January 4, 1896.

Diagnosis of Cancer of the Stomach.—Dr. E. Eisenschutz showed some anatomical specimens from a cancer of the stomach which had developed in a woman on the site of an old cicatrized ulcer. During life the clinical aspect and the chemical analysis of the gastric juice pointed strongly to the diagnosis of ulcer rather than cancer. Repeated examination of the vomited matter or the use of Boas's test-meal showed that the gastric juice contained free hydrochloric acid and that lactic acid and its corresponding bacillus were not present. Symptoms of contraction, frequent hæmatemesis, and the impossibility of retaining food on account of the incoercible vomiting, made recourse to gastro-enterostomy necessary ; the patient, who was greatly weakened notwithstanding efforts at rectal feeding, succumbed to the operation, and at the autopsy a neoplasm was found grafted on an old ulcer.

This case does not disprove Boas's conclusions as to the certainty of the formation of lactic acid in cases of cancer of the stomach, since Boas himself has stated that, while the presence of lactic acid in the gastric juice should decide the diagnosis of cancer, its absence should not cause this diagnosis to be rejected. On the other hand, Rosenheim claims that when a cancer develops on the field of an ulcer of the stomach the chemical reaction of the ulcer persists ; but that, often, after a certain lapse of time the hydrochloric acid disappears and lactic acid will be discovered as usual.

Dr. Teleky said that Boas's theory, which has been generally accepted, is now beginning to be disputed. For instance, in eight cases of pernicious anæmia, Ewald found the reaction of lactic acid without any trace of cancer in seven. The presence of lactic acid is not, therefore, pathognomonic in the diagnosis between ulcer and cancer.

Dr. Singer, on the contrary, believed that the repeated finding of lactic acid in the gastric juice has a decided importance in the differential diagnosis.

FRANCE.

Académie de Médecine

Diphtheria Mortality and Antitoxin in France.—Certain facts and statistics communicated by M. Henri Monod, the Director of the Public Health Department of France, will have interest for all those who desire information as to the use of antitoxic serum as a means of staying the ravages of and preventing death from diphtheria. The system for the registration of deaths is still very imperfect in France, and by reason of this M. Monod is restricted, as regards mortality returns, to 108 towns of 20,000 inhabitants and over; but this gives him a population of 8,150,000 to deal with, although it is limited to that which is practically urban in character. In the 108 towns in France which are in question the mean number of deaths from diphtheria in the first six months of the seven years 1888 to 1894 was 2627. In the three months November, 1894, to January, 1895, the Institut Pasteur distributed over 50,000 supplies of antidiphtheria serum, and this supply, which was maintained, was made available not only for the well-to-do, but also for those who, by reason of poverty, were compelled to receive it by means of gratuitous distribution. Now, in the first six months of 1895, the number of deaths from diphtheria in the same 108 towns was only 904, or a diminution at the rate of 65.6 per cent. The rate of diminution month by month went on almost uniformly from one of 56.2 per cent. for the month of January to 47.5 per cent. for the month of June. On these data alone a saving of 15,000 lives would have been effected during the first half of 1895. M. Monod, however, deals with the matter as an affair of statistics, and does not profess to enter into the question whether the climatic and other unknown causes which influence the power of diphtheria for spread and for death were less operative in the first six months of 1895 than in the corresponding months of the seven antecedent years. Such conditions may have influenced the result to some extent; but it seems impossible to attribute solely to an unknown cause such a diminution in death as he shows in his paper to have gone on synchronously with the wide-spread use of the serum. The facts he quotes are well worthy of consideration by those who have to treat diphtheria either in hospitals or in the homes of the people.—*Lancet*, January 4, 1896.

CONGRÈS FRANÇAIS DE CHIRURGIE.

Surgical Treatment of Neuralgia.—AIMÉ GUINARD, of Paris (*Bulletin Médical*, November 20, 1895), has practiced resection of the infra-orbital nerve and Meckel's ganglion three times for the cure of obstinate facial neuralgia. He is opposed to the removal of the Gasserian ganglion, as being too serious an operation and attended with grave after-effects, and advises, in all cases in which the neuralgia begins in the infra-orbital region, resection of this nerve and Meckel's ganglion, and this even when the pain has extended to the other branches of the trigeminal nerve. Resection of the Gasserian ganglion is, in his opinion, only warranted when extra-cranial extirpation of the trigeminal branches has been tried and failed. In his experience resection of the infra-orbital nerve and its ganglion may bring about a cure of the painful symptoms, even when at some distance from the region operated on.

CHALOT, of Toulouse, stated that he had recently removed the Gasserian ganglion from a man who had already undergone two operations on the nerves and trigeminal ganglia without result. He had rapidly located the Gasserian ganglion, but had found its extirpation dangerous, owing to its proximity to the cavernous sinus, which, at the moment of removal, the tenotome had penetrated, causing abundant hæmorrhage. He had found it necessary to leave a tampon in the wound. The patient died on the following day.

Dubois, of Cambrai, reported three cases successfully treated by extracranial neurectomy, and indorsed Guinard's recommendation to leave extirpation of the Gasserian ganglion as a last resort. In his operations, instead of drawing the infra-orbital nerve forward, as is usually done, he drew it entire into the spheno-maxillary fossa, where it was very easy to recognize and to cut it. The usual severe hæmorrhage he avoided by digital compression of the carotid, thus enabling him to see the superior maxillary at the fundus of the fossa.

Cerebral Surgery.—Doyen attributed the rarity of intervention in diseases of the brain to a want of certainty in cerebral localization and to defective operative procedures, which permit of exploring but a small portion of the surface of the brain. In order to judge of the extent of the lesions present in a certain case it is necessary to be able to completely explore the surface of the lobe. This he has successfully done several times. He makes a large flap from the occipital protuberance to the glabella, prolonging the incision laterally in front toward the zygomatic arch and backward toward the external auditory canal. By means of special burrs, worked by hand or by electric motors, he makes five or six incisions into the bone outside the superior longitudinal sinus, above the lateral sinus and below the temporal fossa, separating the bony septa obliquely so as to prevent depression of the bone when replaced in position. This method renders cerebral localization useless to the surgeon, it being only necessary to have some indications as to the side to be operated upon. The author has, in certain cases, been able to operate on both sides at one sitting. He regards the procedure as applicable to many affections, and especially to epilepsy and microcephalus.—*Méd. Moderne*, November 6, 1895.

Operation in Tuberculous Pyopneumothorax.—Gérard Marchand, in a paper on the surgical treatment of pyopneumothorax in a tuberculous patient, shows that thoracotomy here affords relief in only exceptional instances, and that when the general condition permits of it extensive costal resection is the proper procedure. Simple aspiration with an injection, always dangerous in such cases, is powerless against the cause of suppuration and against the pleuro-pulmonary cavity. The operation for empyema arrests the effusion, but is insufficient to overcome pleuro-pulmonary perforation, the exact spot of which is difficult to determine. Clinical evidence is here valueless, but pathological anatomy demonstrates that pleuro-pulmonary fistulæ, often multiple in tuberculosis, have almost a definite site. This, in the opinion of Béhier, is in the upper lobe, at the level of the third and fourth ribs, in the medio-lateral portion,—an opinion shared by Walsh, West, and Weit. Germain Sée places it between the anterior border of the lung and the axillary line. The large opening made by a lateral incision permits the area to be discovered, and if the pleura is thickened, as it was in one of the author's cases, it can be explored with a cannulated sound, which will lead to the diseased area; it will then be easy to ascertain the limits of the latter by resecting the ribs, sometimes in front of and sometimes behind the axillary line, according to the position of the area or the retraction of the lung. It will also be easy to see the orifice of communication, which is sometimes distinctly circular, like a funnel, and large enough to admit the end of a pen-holder, as in a second case of the author's. Sometimes, on the other hand, it is less apparent, consisting of a sort of valve which opens on inspiration and becomes glued together on expiration, as in M. Marchand's first case. This fistula, which resists all other treatment, closes rapidly after extensive resection. The author regards this spontaneous occlusion after costal resection as a most curious effect, and believes the process to be favored by three factors: 1. The suppression of the passage of pus through the fistula, this being carried off by drainage through the external incisions. 2. The disappearance of the pleural cavity; here the obliteration of the costal wall, which has been deprived of its natural supports, favors union of the soft parts with the retracted lung. 3. The lung itself, in expanding, tends to contract the orifice of communication. These, of course, are mere hypotheses, but the fact remains that spontaneous recovery of the fistula occurs in the first days following costal resection. Tamponading of the pleural cavity may also have some influence here. M. Marchand calls attention to the danger of pleural irrigation when a pulmonary fistula is present, and states that in his first patient he had seen its employment followed by suffocation with asphyxia.—*Journal des Praticiens*, November 2, 1895.

Pneumonotomy for Dilatation of the Bronchi.—M. WALTHER, in discussing this subject, distinguishes between cavities of recent formation and those of long standing. After a recent cavity has been opened for a limited area of gangrene, for instance, it will be seen that, after rapid elimination of the sphacelated portions and disinfection for several days by means of a suitable dressing, the walls of the cavity begin to bud, to swell up, and to take their place in front of the thoracic wall, which has been freed by a sufficiently extensive costal resection. In old cavities, however, the area of disease is surrounded by extensive chronic sclerosis, with aneurismal dilatations, which may cause grave and often mortal hæmoptysis. Whatever be the nature of the disease,—pulmonary gangrene, abscess, or interlobar pleurisy evacuated through the bronchi,—the chief obstacles to reparation of the cavity and to recovery are pulmonary sclerosis and chronic bronchitis with dilatation. The lung does not participate in the process of repair, and the cavity cannot close up except by causing great depression of the thoracic wall. In this case simple resection of the ribs is not sufficient, and total resection by Schede's method must be employed. The conditions for repair are worst where there is great dilatation of the bronchi, the sclerosis being extensive; yet even here surgical intervention may give good results. Walther cites the case of a woman, aged 26 years, with all the signs of partial pyopneumothorax of the lower part of the left pleura, in whom incision of the hard and sclerosed pulmonary tissue gave access to a cavity occupying the entire lower lobe of the lung and having the appearance of an enormous bronchial dilatation. An extensive resection caused the disappearance of the cavities and diminution of the expectoration. There remained but a small upper diverticulum after a couple of months, which Walther opened after resecting the fourth and fifth ribs, destroying with the thermo-cautery several orifices communicating with the bronchi. Ten months afterward the patient appeared to be definitely cured, the old lesions of chronic bronchitis of the upper lobe being present, but the large cavity of the lower lobe having entirely disappeared.

Exploratory Incisions in Pulmonary Disease.—M. Bazy, of Paris, called attention to the usefulness of exploring the pleural cavity in order to recognize the seat of a pulmonary lesion. He operated in January, 1894, on a young man of 20 years, suffering from pulmonary gangrene with abundant expectoration. All the signs appeared localized to the base of the right lung. Having made an incision ten centimetres long to the parallel ninth rib, he resected six centimetres of the eighth and ninth ribs. The pleura appearing to be normal at this point, he incised it sufficiently to introduce the index finger and explored the pleural cavity in every direction. He met with some adhesions above, at the level of which the lungs appeared to be indurated. He therefore closed his first incision and made another transverse one corresponding to the fourth rib, resecting this and the third for a distance of three centimetres. Then with the thermo-cautery he incised the lung, finding a cavity filled with badly-smelling pus. He curetted this and put in a drain to a depth of ten centimetres. The immediate result was remarkable, but, unfortunately, the patient died four or five months afterward of an attack of epilepsy.

Drainage in Thoracic Surgery.—M. Delagenière, of Mans, insisted on the relation between pleural and pulmonary surgery, especially in septic affections, which comprise the majority of cases operated on. As inoculation of the pleura would be fatal, the latter should always be drained and disinfected in operating on the lung. This may be accomplished by resecting the sixth, seventh, eighth, and ninth ribs and draining the costo-diaphragmatic *cul-de-sac*. Opening of the serous membranes in the track of the eighth rib permits of exploring the pleura, the lower lobes of the lung, and the interlobular scissures, if an additional rib—the fifth—be removed. Access to the lesion may be facilitated by freeing the parietal pleura from its ribs, as the author has recently done in a case where it was necessary to separate the stump of the lung from its visceral pleura. He has also successfully carried out these ideas in three cases of lesions of the lower lobes, one of extensive gangrene, one of a large suppurating hydatid cyst, and one of abscess. The pleural indications are the same in affections of the upper lobes and apex, but the pulmonary lesion must be treated separately, either by a second operation at the same time or, in certain cases, by a separate operation afterward.

Michaux stated that, of eleven cases of wounds of the lung surgically treated, in only four was there hæmorrhage. He believes that the mortality in cases of extensive effusion of blood, of pleuro-pulmonary origin, is at least 50 per cent., and that surgical intervention is therefore justified. Hæmorrhage is not the only indication, hernia of the lung and the presence of foreign bodies of greater or less size also warranting operation.

From two cases operated on by him for small cavities in the lung he was led to the conclusion that these organs are extremely tolerant of traumatism, since he was able to puncture and incise with the thermo-cautery without causing great hæmorrhage or later untoward results.—*Sem. Méd.*, October 23, 1895.

Société de Chirurgie.

Pneumonotomy for Deep Thoracic Effusions.—M. Tuffier, in opening a discussion on this subject, said that, while all observers were in accord as to the elevation of temperature in pleural effusions, they were not in accord as to the pathogeny of this elevation. Michaux attributes it to a traumatic pneumonia, while Tuffier is inclined to agree with Lucas-Championnière that it is due to the absorption of blood.

Pleurotomy being decided on in these cases after medical examination, any adhesions must be taken advantage of to make the incision at their level, without in this case detaching the pleura. The thermo-cautery or, preferably, the bistoury can be used in making the incision. When there are no adhesions, some authors advise direct incision of the pleural layer. Tuffier, however, believes that this should be regarded as a last resort, and that other measures should first be tried, since this operation may give rise to serious accidents, disturbances of respiration resulting from contraction of the lung. In one case of pulmonary gangrene in which he operated retraction of the lung and symptoms of asphyxia followed an incision at the point indicated by medical exploration, and he was obliged at once to suture the lung to the pleural incision and close the cavity of the pleura in order to combat the dangerous symptoms. Another point is that incision of the pleura does not always open up the morbid area, as evidenced by many cases. Detachment of the pleura appears to Tuffier to be here far preferable, and, by performing it about the incisions, it is easy to find adhesions, if any exist, and to learn in this manner that the diseased point is not far distant. As regards the gravity of the operation, no immediate accident need be feared; at least, none had been observed in cases of his own and of Quénu. Later accidents depend not upon the operation, but upon the gangrene. Hæmorrhage occurred on the sixth day in one of his cases and in another when the tampon was removed.—*Bull. Méd.*, December 15, 1895.

Wounds of Thorax.—M. Quénu, in reporting two cases of penetrating wounds of the thorax, remarked that in one of them the intercostal artery had not been wounded, though the loss of blood had been great and the effusion so considerable as to render operation necessary. The seventh rib having been resected, the pleura was incised and the lung found to be retracted, except in the lower portion, where it was adherent to the parietal pleura, some blood-clots, which were here, being removed. The cavity was filled with iodoform gauze, which, when removed several days later, was found to be scarcely tinged with blood; the patient left the hospital cured within fifteen days. Quénu believes that in cases of hæmorrhage following traumatism, which, however, may be followed by recovery without incision, such intervention should be practiced more frequently than it is, being free from danger and favoring retraction of the lung. It is naturally more strongly indicated when the hæmorrhage is persistent.

M. BERGER said that the hæmorrhage in such cases could often be arrested by tampons.

M. DELORME believed it best to wait and see if the hæmorrhage were not spontaneously arrested before operating or until symptoms of infection became evident.—*Bull. Méd.*, November 10, 1895.

SOCIÉTÉ MÉDICALE DES HÔPITAUX.

Relapsing Measles.—MM. A. CHAUFFARD and G. H. LEMOINE, in a paper on this subject, stated that the question of relapse in measles had given rise to much doubt and discussion, some authors believing that in certain cases there might be either a temporary retrogression of the exanthema, or an accidental medicinal or sweating eruption added to the original one, or the succession in the same patient of roseola or rubeola, followed by true measles. In fact, all these combinations may have been observed, simulating a real recurrence of measles.

But, putting aside these causes of error, there remains a series of cases which seem undoubted, and in which the diagnosis seems legitimate. The authors were not inclined to regard this as surprising, since relapse is one of the common clinical forms of many acute infections, such as typhoid fever and scarlatina. Again, measles is the most frequently recurring eruptive fever, and such recurrence confers the least durable immunity of any of these diseases.

The authors presented a double series of cases observed last spring: the first in the isolated ward for measles at Val-de-Grâce, the others in an epidemic which appeared in a family of seven children and a servant. In all eleven cases with relapses were seen in the two epidemics at about the same time, April, May, and June, 1895,—that is, in probably identical conditions of virulence of the epidemic. These cases are convincing, and all accidental, medicinal, or sweat eruptions can be eliminated, though the authors are not sure they are safe in ezcluding rubeola, a still imperfectly known fever, rare in France, but which constitutes, nevertheless, a clinical entity, a number of examples being reported in 1886 and 1890. Several of the cases observed in the family epidemic recall rubeola by the benign character, apyrexia, the short duration of the exanthema, and even, in two cases, by cervical adenopathy, although this was very slight and painless. All the eruptions which were seen by Chauffard and Lemoine, however, whether primary or secondary, had all the classical characteristics of measles exanthema, and not the polymorphous aspect, occasionally scarlatiniform, which all authors have noticed in rubeola. The localized angina was very slight, while the oculo-nasal catarrh was almost constant, and often of equal intensity in the two successive attacks of the disease. As regards the relative gravity of the two attacks in the majority (six cases), the relapse was of the same intensity as the first attack of the measles; twice it was more severe and twice more benign. But none of these cases, primary or secondary, was really severe; still less malignant, complicated, or abnormal. This is an important fact, for it permits the supposition that the pathogenesis of the relapse cannot be explained by an increased virulence of the germ. From the two series of cases observed by them it would appear that *overcrowding* was the more probable cause of relapse.

The first group of cases was seen in an isolating service, overcrowded from the month of January; the second, eight cases, developing one after the other in the same family. It can be easily understood how such centres can become saturated with the still unknown specific germ of measles, and what power of contagion this germ may acquire. If the convalescent has acquired but a slight immunity from the first attack (and this depends on the element of individuality), he may become re-infected and have a relapse. This the authors consider an exaggerated rubeolic infection, as already suggested by L. Guinon (*Traité de Médecine*, vol. ii, p. 95),—a theory which seems very plausible.

In several of the patients the identity of the clinical picture in the two attacks was such that to admit that one of them was true measles and the other rubeola would really be a recognition of the impossibility of making a clinical differentiation between these two eruptive fevers. Moreover, the simultaneous and chance outbreak in the same surroundings of two infectious exanthemata, one independent of the other, seems an unsatisfactory hypothesis. For these reasons the authors think that their diagnosis of relapsing measles is justified.

These cases show great differences in the intervals between the first and second eruptions, which lasted 27, 20, 12, 20, 12, 30, 14, 40, 20, 31, and 21 days, respectively, and hence do not aid in determining the duration of incubations of the relapse, for, although nothing is more certain than the time between the contagion and eruption in measles, the same may not be true for the relapse. In relapses from typhoid fever the rose spots appear much earlier than in the first typhoid cycle.

M. Béclère thought it quite possible that in Chauffard and Lemoine's cases there were two simultaneous and successive epidemics,—one of measles, the other of rubeola. This supposition is all the more probable since there is no pathognomonic symptom differentiating the two affections.

M. Bucquoy stated that he has seen a certain number of cases similar to those of Chauffard and Lemoine, and confirming them, but he did not think that they were due to a re-infection, but more probably to an interrupted action in two stages of the same virus,—that of rubeola.

M. Siredey, in referring to Chauffard and Lemoine's tendency to consider that overcrowding might have been responsible for the relapses, said that, while this was quite possible, he had not observed any case of this kind at Aubervilliers last year in a ward for measles which was greatly overcrowded.

M. Comby stated that, of more than seven hundred cases of measles observed by him at the Hôpital Trousseau, he had not seen a single case of recurrence or relapse. He recalled the diagnostic value of the buccal exanthema to which he has previously drawn attention, and which is not met with when the eruption simply resembles measles.

M. LE GENDRE had studied this exanthema, and had found it in many cases of measles, but also in scarlatina; so that it could hardly have a pathognomonic value.

M. SEVESTRE had seen two clear cases of recurrence in measles.—*Bulletin Médical*, January 1 and 8, 1896.

Migration of Pus to Lumbar Region in Pyopneumothorax.—GALLIARD, in a paper on this subject, stated that the migration of empyema to the lumbar region has been studied by Delosse (*Thèse de Paris*, 1884), who, in eighteen collected cases, found that the purulent collection had formed a tumor twice on the right side and six times on the left. None of these patients had pneumothorax. In one of them, however (Grisolle), a vomica existed. M. Galliard observed a case in which a large lumbar abscess, situated on the right side, under the skin, in a tuberculous patient 40 years of age, together with total right pyopneumothorax, had existed for several months. The tumor was reducible, fluctuating, and non-pulsatile (abscesses of the left side are sometime pulsating). After puncture and evacuation of pus air entered the cavity; a splashing sound could be heard, and the air was expelled with a whistling noise when the patient coughed. Cachexia was too far advanced to authorize an attempt at a radical cure, and death occurred at the end of two months. At the post-mortem examination the right pleura was found to be entirely devoid of pus and the lung reduced to a shapeless stump. The costo-diaphragmatic sinus was posteriorly the seat of a sort of infundibulum, the lower extremity of which passed below the last rib and continued—by means of a track five centimetres long—through the muscles of the loins, ending in the pocket of pus which the author had opened during life.—*Bulletin Médical*, November 17, 1895.

SOCIÉTÉ DE BIOLOGIE.

Experimental Extirpation of the Liver.—M. KAUFMANN, of Paris, performed a series of experiments on animals to determine the effect of extirpation of the liver. He removed the organ, maintaining the circulation in the body, but suppressing it in the abdominal viscera or extirpating the latter. The animals survived, on an average, four or five hours. In dogs rendered diabetic by extirpation of the pancreas the quantity of sugar in the blood was diminished on removing the intestines, while in the normal animal the quantity was increased. If the portal vein were occluded, but the hepatic artery and the liver left intact, the quantity of sugar in the blood is diminished, the hepatic artery being insufficient for glycogenesis. The portal vein is thus the functional vessel of the liver and the hepatic artery only the supply-vessel. His experiments appear to him to show that increased sugar in the blood is the result of increased action of the liver.—*Bulletin Médical*, October 27, 1895.

GERMANY.

BERLIN MEDICAL SOCIETY.

A New Method of Isolating the Typhoid Bacillus.—HERR ELSNER described a simple and certain method of isolating the bacillus of enteric fever. After boiling gelatin together with an infusion of potatoes a quantity of soda is added and the mixture filtered and sterilized. It is put into tubes filled with a 1-per-cent. solution of iodide of potassium. The tubes are then inoculated with the dejecta and the gelatin is deposited on glass plates in the usual way. The researches of the author prove that all bacteria perish in the iodide-of-potassium gelatin except the bacillus of enteric fever and the bacterium coli commune. After twenty-four hours the bacillus of enteric fever is scarcely visible on the gelatin, but the colonies of bacterium coli are already somewhat large at this period. After forty-eight hours the colonies of the enteric-fever bacillus become visible as small, clear masses like drops of water, whereas those of the bacterium coli are large and of a dark-brown color. No other bacteria of the dejecta besides the two above named, are to be seen. Herr Elsner found the bacillus after forty-eight hours in every stage of the illness in twelve cases, the number of the bacilli decreasing as soon as the temperature became lower. In one case complicated with thrombosis of both crural veins they were present after thirty-eight days. If after the cessation of the fever the bacilli are still visible in considerable quantity a relapse is probable.

PROFESSOR BRIEGER suggested that the dejecta of persons who have to do with enteric-fever patients—such as nurses, servants, etc.—should be regularly examined. If bacilli are found these persons must be supposed to be in the stage of incubation and full doses of calomel may be able to prevent the development of the illness.

Tumor of Mediastinum.—THIELE presented anatomical specimens from a young woman who, for several weeks, had experienced a sensation of heaviness in the head and attacks of cough without expectoration. There had of late also been increasing dyspnœa and cyanosis of the face. Examination revealed the presence, in the anterior portion of the thorax, of an area of dullness extending from the sternum right and left to the axillary line. All respiratory murmurs were absent in this area and the heart-sounds were perceived as through a layer of cotton. There was no anomaly of the larynx or tracheal artery. A tumor of the mediastinum was diagnosed, and on account of the age of the patient and the rapid evolution it was thought to be a lymphosarcoma. This diagnosis was verified at the necropsy, the patient dying twelve days after admission to hospital.

H. KOHN related the case of a patient in whom he had diagnosed a tumor of the lung or of the mediastinum, in which an autopsy showed chronic inflammation of the lung. With the addition of paralysis of the vocal cords he presented exactly the same symptoms as another case of the author's,—chronic inflammation of the lungs had been diagnosed and an alveolar sarcoma of the lungs and bronchi found at the autopsy.

ITALY.

Medical Society of Bologna

Action of Certain Foods on the Heart and Respiration.—Dr. Pugliese reported the results of his experiments concerning the action of certain alimentary substances on the cardiac and respiratory functions. Sugars, fats, peptones, and gelatin considerably increase the number of heart-beats, so much so that their number may be raised from 60 to 120. This increase is apparent one hour after the ingestion of the aliments. Respiration is not affected by any of these substances with the exception of gelatin, which has a very decided action and may increase the number of respirations to double the normal number. Cane-sugar and glucose, in large doses, have sometimes had a similar action. Pugliese thinks that these substances act directly on the myocardium, as demonstrated by Albertoni in the case of glucose.

Iodol in Venereal Disease.—Dr. Majocchi has used iodol in about eight hundred cases of soft and hard chancre and erosion of the neck of the uterus. In soft chancre a healthy granulation was quickly obtained at the base of the ulcer, while in hard chancre the induration quickly disappeared. An important point in the treatment, and one essential to its success, is that the base of the ulcer should always be carefully cleansed, in order to prevent decomposition of the iodol. As to the mode of action of iodol, it is known that it gives out iodine, which sets up irritation in the surrounding tissues.

Action of Air on Tubercle Bacilli.—Dr. Origi, in an attempt to decide whether it would not be possible to hasten the usually slow development of the tubercular bacillus by passing a stream of air through the receptacle containing the culture of this microbe, made the following experiments :—

The flow of air was regulated by a Flécher pump. The cultures in glycerin bouillon were placed in bottles having two tubes. Before passing into the culture-recipient the air entered through these two U-shaped tubes, one of which contained sublimated cotton and the other sterilized distilled water; so that the air was cleansed, so to speak, and also acquired the necessary degree of humidity. The first experiments were made on bacilli previously in order to determine if it were possible to restore their original virulence. In cultures on agar glycerin, and also on glycerin bouillon, the author was able to obtain, in from eight to ten days, visible white spots. The development of the bacilli was much more rapid in Erlenmeyer's bottles, simply sealed with cotton-wool, than in those closed with gum or paraffin corks. From these experiments the author concludes that a draught of air passing through a culture of tubercle bacilli apparently influences the development of this microbe.

Italian Congress of Obstetrics and Gynæcology, Rome.

Puerperal Infection.—The interesting and important question of general and local intoxications as predisposing causes of puerperal infection was considered by Rossi-Doria (*Riforma Medica*, November 18, 1895), who, after recalling the work of Tommasoli, Krönig and Doderlein, and reviewing general intoxications, those of fæcal origin and those caused by intercurrent infectious diseases, concludes as follows:—

1. The etiology and prophylaxis of puerperal infection is still uncertain and contradictory. 2. This arises from the fact that so much more account is taken of the infectious element than of the infected organism, whereas all puerperal infection comes from the reciprocal and equally important action of the two factors. 3. The healthy organism possesses numerous means of resistance and defense, which are in great part chemical in nature. 4. These means of resistance may weaken in different parts of the economy, and their progressive weakening is the cause of the progressive increase of the infectious element. 5. The cause most likely to weaken these powers of defense is represented by the intoxications. 6. These intoxications may be either general or local. The first exert a direct general action and an indirect local action, lowering the vitality of the whole organism and therefore that of the genital tract. The second exert an indirect general action and a local action, causing weakening of the tissues of the genital tract, thus preparing it for a more or less rapidly invading infection. 7. For these reasons the expression "auto-infection" merits preservation, since it expresses a real condition; it should, however, retain the meaning given it by Semelweiss,—viz., a process by which germs of external origin dispose the organism to infection, either by an increase in their virulence or by decreasing the powers of resistance of the body. 8. In the prophylaxis of hetero-infection—that is, where the germs come from outside—careful asepsis is sufficient; in auto-infection, besides the measures taken to increase the powers of defense of the organism, antiseptics may be resorted to. 9 These, however, have the disadvantage of preventing nature from acting, the results of prophylactic measures seeming to afford a reason for denying the auto-infection which may really be present. 10. Prophylactic measures certainly have the great merit of preventing conditions tending to interfere with the defense of the organism and of thus opposing auto-infection; but it must not be forgotten that the defense of the organism alone is not always sufficient, and that sometimes auto-infection occurs without the influence of any external agent. 11. The auto-defense of the organism against puerperal infection is represented (*a*) by the vaginal and cervical secretions, which possess a bactericidal and antitoxic action, as do all the liquids of a living and healthy organism. These secretions should not be removed. (*b*) By the continuity and integrity of the epithelial covering, which should be preserved by every possible means. (*c*) By the vitality of the cellular elements of the walls and regions adjacent to the genital tract. Mortification of the tissues should, therefore, be carefully guarded against. (*d*) By the activity of the antitoxic functions of the organic liquids which bathe the tissues of this region. The local and general production of poisons tending to lessen this bactericidal power should be diminished as much as possible by the removal of putrid substances, and the quantity of antitoxins artificially increased as much as possible by the use of serum therapy. (*e*) By the ana-

tomical and physiological integrity of the organs destined to neutralize circulatory poisons (suprarenal glands, thyroid gland, and liver). Any existing disease of these organs should, therefore, be first treated in order to facilitate their functions. (*f*) By the anatomical and physiological integrity of the organs destined to eliminate these poisons. The intestinal and renal functions should be very carefully watched and facilitated by the usual measures, taken in time. 12. The combination of practices tending to prevent auto-infection (including the auto-defense of the organism) with others equally useful, but too often badly applied (antiseptic douches), and aseptic measures, the most useful of all, form a complete system of rational therapeutics in peripheral infection.

ITALIAN SURGICAL CONGRESS.

Resection of the Astragalus.—CASELLI (*Riforma Medica*, No. 263, 1895) explained a new method of astragalo-tibial resection by means of which a larger bony surface for apposition is obtained and all cavities avoided,—a particularly important point in cases of chronic inflammatory and infectious disease. Caselli's procedure is indicated when the lesion involves the lower extremities of the tibia and fibula, the astragalus, and even the scaphoid and cuboid, but the os calcis must be intact. The technique of the operation is as follows: The external incision is made four centimetres above the external ankle (adult), describing a curved line with anterior concavity seven to eight centimetres long. The external malleolus is uncovered, isolated, and removed, and the astragalus separated and removed in the same manner. A second incision is made on the inside of the foot parallel with the external incision, the lower end of the tibia resected level with the tibio-peroneal vault if the lesion is limited and higher up if it is extensive. The scaphoid is removed or left, according to its condition. The upper part of the calcaneum is resected in such a manner as to form an horizontal plane, adapting itself to the plane of section of the tibia and fibula. The result is a disposition of the bones similar to that of Pirogoff's operation as modified by Pasquier and Lefort, except that the front part of the foot is preserved intact. The tibia and fibula are fixed to the os calcis by metallic sutures.

According to the author, the final results of the operation are satisfactory, all the movements of the foot being perfect and only the shortening corresponding to the height of the astragalus removed and of the tibia and fibula resected being present. Caselli has performed this operation seven times and always with excellent and lasting results.

UNITED STATES.

NEW YORK ACADEMY OF MEDICINE.

Bloodless Amputation of Shoulder-joint.—DR. JOHN A. WYETH gave the history of a case in which the transversalis colli and suprascapular and subclavian arteries (third division) were tied, under cocaine anæsthesia, with subsequent bloodless amputation of the shoulder. The patient was a man, aged 31 years, by occupation a groceryman, with no early personal or family history, who, in 1889, had received an injury of the left arm near the shoulder-joint which he considered a fracture and from which he recovered with some stiffness of the joint. He noticed nothing of interest beyond this until 1893, when, in descending from the deck of a ship, he caught hold of a rope to prevent himself from falling, and severely strained this same arm, and remembers having heard a ripping sound, followed by great pain. Four or five months after this injury he noticed that the arm began to swell. It was not excessively painful, except on sudden motion.

When first seen, on October 2, 1895, there was a large, round swelling, which occupied the upper end of the humerus, the deltoid region, and extended somewhat over the end of the clavicle and scapula. On October 5th, under chloroform anæsthesia, an exploratory incision was made for the purpose of getting a specimen for microscopical examination. Cutting directly down through the deltoid muscle, Dr. Wyeth came immediately into a large, vascular osteosarcoma, which had hollowed out the medullary canal and substance of the head of the humerus, into which he passed two or three fingers very readily. The bone gave way with a peculiar crackling sound, like the breaking of an egg-shell, and was followed by profuse hæmorrhage, which could only be arrested after rapidly packing the cavity with at least three yards of sterilized gauze ; over this an Esmarch elastic bandage was carried. This hæmorrhage greatly weakened the patient, and by October 9th, becoming alarmed at the anæmia, Dr. Wyeth injected into the right median cephalic vein 1½ pints (750 cubic centimetres) of hot saline solution, 1 drachm (4 grammes) of salt to a quart (litre) of water. This was followed by a rapid improvement in the heart-action, fuller pulse, better appetite, and increasing strength. There was, however, considerable hæmorrhage whenever the packing in the tumor was changed ; so much so that, on October 15th, in order to control this bleeding and to dispense with the packing, which was so tight that it caused him a great deal of suffering, the left transversalis colli and the suprascapular and left subclavian arteries, in the third surgical division, were tied. The operation was not easy of accomplishment, by reason of the great swelling of the shoulder, which lifted the clavicle fully an inch higher than the normal position and prevented the manipulation of the parts, displacing the clavicle and shoulder on account of the great pain. The patient could not tolerate any pressure upon the shoulder. Dr. Wyeth was afraid to administer ether or chloroform on account of his exhausted condition and he therefore tied the arteries by the judicious employment of cocaine, 25 minims (1.6 cubic centimetres) of a 4-per-cent. solution being employed. The operation was quite tedious, and the subclavian artery, when finally exposed, was two and one-half inches from the surface of the wound and deep below the clavicle, where it was caught up by an aneurism-needle and tied. The patient lost practically no blood from the incision in the tumor after this operation.

On October 20th, under ether anæsthesia, a rapid, bloodless amputation of the shoulder-joint was performed by the method which Dr. Wyeth first employed in doing this operation in 1889, and which consists in the insertion of two steel pins about fourteen inches long and less than a quarter of an inch in diameter. The anterior one passes through the skin and part of the pectoralis majoralis muscle, well back behind the level of the shoulder-joint. Not more than one and a half inches of this pin should be concealed by the tissues it perforates. Over the spine of the scapular, well up behind the joint, the second pin is passed, taking hold of nothing but the integument, and perhaps a little of the surface of the trapezius muscle. Around the shoulder, over the clavicle and scapula, and behind the pins, the points of which are shielded by bits of cork, strong rubber tubing is tightly wound four or five times and then tied. The amputation can then be made at leisure, disarticulation completed, and the vessels taken up at will. The operation is entirely bloodless, and the tourniquet need not be removed until the procedure is completed. It is always advisable, however, to loosen the tourniquet before the final suturing in order to see that no important bleeding-points have been overlooked.

He has performed, three operations of a similar nature by this method, and a number of others have been done by competent surgeons without hæmorrhage in any instance. He has also employed it in seven amputations at the hip-joint, with no hæmorrhage in any case and only one death from the operation. The tourniquet remains in position until the operation is nearly completed.

In the present case, it being one of malignant tumor, and as the soft parts up to the level of the joint seemed to be involved, he did not endeavor to cover the joint surface with cutaneous flaps, intending as soon as the wound began to granulate and the patient recovered sufficiently, to infect it with some septic organism, preferably with streptococci erysipelatis. On November 19th an injection of 5 minims (0.32 cubic centimetre) of a pure culture of Fehleisen's coccus was made, and was repeated every other day, gradually increasing the dose by 3 minims (0.20 cubic centimetre) until 26 minims (1.66 cubic centimetres) were injected. No regular erysipelas, however, occurred, though there were septic chills with exacerbations of temperature following, which on one occasion reached 40.7° C. (105.2° F.). These injections have been discontinued for the time being, and, despite the severe ordeal he has undergone, the patient has gained flesh and weight and there is no sign of recurrence.—*Medical Record*, December 21, 1895.

Boston Medico-Psychological Society.

Multiple Neuritis the Essential Element in Landry's Paralysis.—Dr. George L. Walton, in reporting a case of Landry's paralysis in a man of 30 years who had been operated on for renal calculus, stated that, in respect to the etiology, it is a significant fact that in most of the recorded cases in which a cause was assigned—that is, in about half—the cause was one generally recognized as giving rise to multiple neuritis; for example, alcohol, septicæmic processes, syphilis, and acute infectious diseases. When we come to consider the pathological findings, the majority of autopsies may be disregarded as not sufficiently complete and accurate, from a microscopical and bacteriological point of view, to be conclusive. Certain it is, however, that various careful post-mortem examinations have revealed sufficiently marked changes to give a clue to the process; notably the following:—

Centanni found marked interstitial neuritis and micro-organisms in the cord. Oettinger and Marinesco found nothing in the peripheral nerves, but in the gray matter of the spinal cord found infiltration of vessel-walls with leucocytes, the latter filled with microbes (diplococcus), also with megarocytes with vacuoles and degeneration due to streptococcus. Eisenlohn found degeneration of peripheral nerves, also acute myelitic processes, and micro-organisms in the cord, as well as in the peripheral nerves. Pitres and Vaillard found marked degeneration of peripheral nerves, but nothing in the cord. Baumgarten and Curschman found, respectively, bacilli of malignant pustule and of typhoid in the cord. Hun, who opposes the view of neuritis and regards the disease a clinical entity, found only a few degenerated fibres of the anterior roots of the cauda equina and cerebral and spinal meningitis of recent origin.

In view of the frequent implication of the cord, as demonstrated by autopsy, it may be pertinently asked: Why classify the disease under neuritis? But, conversely, it may be asked: Why, in view of the frequent implication of the peripheral nerves, should it be classed under spinal diseases? In other toxic disorders, notably lead poisoning and diphtheritic paralysis, in which peripheral neuritis is considered the essential process, the cord is sometimes also invaded, and cases of so-called Landry's paralysis, though more acute, correspond much more nearly to this type of disorder than to disease of the cord. This is certainly true of the convalescent cases, which offer opportunity for careful study, and, even in the cases rapidly succumbing to the overwhelming effects of the poison, signs are present that the nerves are also affected (pain and tenderness being frequently present), though the cord and brain are also attacked by the products of infection. The restlessness and hysterical tendency often noted at the onset certainly point to temporary involvement of the former organ.

The cranial nerves are occasionally affected, though the cerebral symptoms are generally limited, if present, to those mentioned. In Dr. Walton's case the restlessness was extreme, and temporary diplopia showed slight implication of the cranial nerves, other than phrenic and pneumogastric. These considerations would seem to justify material modification of the disease, and the author suggested that it might fairly be described as follows:—

Landry's paralysis is an acute toxic disease characterized by rapid loss of power in the lower extremities, trunk, and to a less degree in the upper extremities, affecting also the vagus and phrenic, sometimes other cranial nerves. The affected muscles are lax. Pain, paræsthesia, anæsthesia, and tenderness are generally present in varying degrees, though in some cases sensory disturbances are wanting. Death follows in more than half (64 per cent.) of the cases. Recovery, when present, is very slow. The reflexes, deep and superficial, are lost at an early stage; wasting and degeneration reaction appear if the patient survive. The process is a toxic affection of the peripheral nerves (neuritis), cord, and brain, the former being the essential and persistent lesion.

DR. J. J. PUTNAM was inclined to agree with Dr. Walton's views with regard to the close analogy of the Landry symptom-complex to that of multiple neuritis; but multiple neuritis is itself a complicated matter, and it seemed to him more rational to preserve a name like Landry's paralysis, as identifying a class with a definite symptomatology, than to limit ourselves to a term supposed to indicate the pathology. He alluded to the fact that the brain and spinal cord showed changes in neuritis, as in Landry's paralysis. In his own case the spinal cord was slightly involved, the axis-cylinders in the lateral tracts being very much swollen here and there. As regards the etiology, the symptoms certainly occur under various conditions, but it is possible that the real causes are fewer in number. In one of his cases the onset was preceded by a ride on the outside of a horse-car on a wet and cold night. In another case, that of a young girl, no exciting cause was found.

No particular reliance can be placed on the discovery of bacteria in small number, as in Centanni's case. In fact, it is probable or possible that no characteristic bacteria will ever be found, the process being perhaps the result of a toxin or ptomaine poisoning. Even in cases where pathological changes are found the symptoms may be due not to them, but to the direct action of the poison on the nerves or nerve-centres. It is probably this which gives the disease its characteristic stamp.

DR. MORTON PRINCE agreed with Dr. Walton that it would be better to take Landry's paralysis out of the spinal diseases, but thought it a partial view to simply call it a neuritis, because its pathology is more extensive than this would imply. Statistics are misleading, for many cases of multiple neuritis have been reported as Landry's paralysis; and if these are included in the statistics, it is reasoning in a circle to prove the disease neuritis by such statistics. Unquestionably many cases of multiple neuritis have been reported as Landry's paralysis, but this does not make them such, and such statistics give erroneous symptom-pictures. That multiple neuritis may suddenly develop in Landry's paralysis has been proved to be true. This is only a partial view. The same is true of other diseases.

Beriberi results in a multiple neuritis, but it is not fair to call it a neuritis alone. The same is true of diphtheritic paralysis. It is better to compare the primary disturbance to a paralysis resulting from a poison like curare and other chemical poisons which have a special action on the motor nervous elements and may lead to inflammatory changes in the cord and nerves. Although Landry's paralysis leads secondarily to neuritis, it follows a certain type; it is very fatal and has special characteristics. Poliomyelitis has actually been found; and to classify the disease under multiple neuritis is like calling all membranous sore throats diphtheria. Such membranes may reveal either streptococcus, staphylococcus, or the Klebs-Löffler bacillus, the course of the disease varying according to the poison. It is better to keep Landry's paralysis as a distinct clinical entity for the present, but to bear in mind the anatomical changes that may be present.

Dr. Prince also showed sections of spinal cord and nerves taken from a case twelve hours after death. No abnormality was apparent in either.

Dr. Courtney thought the term "ascending paralysis" should be dropped, as the course of the disease did not always justify this description. He would prefer retaining the name Landry's paralysis.

Dr. P. C. Knapp alluded to Dr. Walton's statement as to the possible disappearance of the term Landry's paralysis as a designation of a special disease. It is a curious fact that, on looking through the files of nine of the leading neurological journals, extending back over periods of from three to ten years, Dr. Knapp had found no article on Landry's paralysis, nor, in a tolerably well stocked library, had he any monograph or reprint except Dr. Hun's paper. The literature is thus not very extensive and is to be found chiefly in the general journals. Many cases have undoubtedly been called Landry's paralysis which do not fill the requirements nor present the characteristic symptoms. Dr. Sanger Brown reported a case where, in addition to an acute ascending paralysis, there were ataxia, increased knee-jerks, and diminution of tactile and thermal sensibility, which helped to support Carter's hypothesis that a chill might cause dropsy of the central canal of the cord and give rise to the symptoms. Hun has attempted to define the symptoms more exactly and to exclude all cases where there were no bulbar symptoms and where there were sensory disturbances. If we adopt such restrictions we must exclude many of Ross's ninety-three cases. That many of the reported cases of Landry's paralysis are really cases of multiple neuritis must be admitted; but we must also admit that there are many cases presenting the typical symptoms as given by Landry which are not multiple neuritis and in which the autopsy shows no lesion of the peripheral nerves. Out of 24 autopsies which Dr. Knapp has collected the nerves were affected in only 9 and the cord in 15, and in many of the cases in which there were cord-lesions the nerves were found to be normal. The clinical history of the cases, too, is not like that of neuritis, for it is certainly very rare to find neuritis with bulbar symptoms and without sensory symptoms. It seems to him that Landry's paralysis must be regarded as due to some toxin, or perhaps to some bacillus, although Centanni's special bacillus has not been found by late observers. It may act somewhat like lead, only more acutely. There has been much dispute as to whether the lesion in lead was in the peripheral nerves or in the cord, changes being found in both regions, but the recent work of Stieglitz renders it probable that lead attacks the whole peripheral or centro-muscular motor neuron. The visible changes from the poison are usually first manifest in the part of the neuron most remote from the muscles, the axis-cylinder of the nerve, and later in the cell itself. The earlier changes may appear in other equally remote parts of the neuron, the collaterals in the cord rather than the fibres of the peripheral nerve. It is possible that this unknown toxin has a similar action. We are not, at any rate, in the light of the autopsies, justified in adopting Ross's sweeping assertion that all cases of Landry's paralysis are nothing but multiple neuritis.—*Boston Medical and Surgical Journal*, December 26, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM
FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

Alterations of the Spinal Cord in Pernicious Anæmia.—In an inaugural dissertation (Stockholm, 1895), CHARLES PETRÉN states that in pernicious anæmia small hæmorrhages and consecutive sclerosis are frequently met with in the spinal marrow. These hæmorrhages have no significance from a clinical point of view. The vessels often show thickening and commencing hyaline degeneration, not, however, as a rule, combined with degeneration of the nervous elements. From a study of the literature it appears that comparatively few cases of pernicious anæmia present a real disease of the spinal cord. The symptoms of anæmia remain unchanged in cases in which it does occur, and it is difficult to explain why the cord should be affected in some cases and not in others. The disease of the cord manifests itself with somewhat varying symptoms, certain of which, however, are exhibited in all cases. From an anatomical point of view the alterations have considerable variations, but this is accounted for to a great extent by the fact that the process has been observed at a different stage in the various cases; from a closer analysis of the cases it appears that the degeneration progresses in a fairly regular manner. It is presumable that these cases of disease of the spinal cord form a special group, even from a neurological point of view. It may be admitted that some toxic condition is the common, immediate cause of the disease of the spinal marrow as well as of the anæmia. The alterations of the spinal cord are here wholly different from those found in tuberculosis and diabetes, where the changes can easily be distinguished by slightly-marked and chronic degeneration, such as is often found in Addison's disease.

The Olfactory Lobe in Mammals.—GUSTAV RETZIUS ("Trans. of the Swedish Medical Society," pp. 83, 85, 1895) finds that in mammals the medial root of the olfactory tract (or the so-called olfactory nerve) can be followed upward and inward as far as the gyrus fornicatus and the indusium corporis callosi, while the lateral, larger root may easily be followed in the human fœtus outward through the limen insulæ Reilii, and farther inward to the lobus hippocampi, where it invariably bifurcates. The end of the inner branch is a rounded protuberance, a small gyrus of a lighter color than the surroundings, the external branch taking a curved course and extending as a low ridge outside the internal round protuberance to the anterior end of the gyrus uncinatus, where it disappears. Both these gyri manifestly form the posterior ends of the dichotomous, larger roots of the olfactory lobe, which here go deeply into Ammon's horn, the gyrus uncinatus and the gyrus hippocampi, where their terminations can be seen in every fœtal brain from the fourth month till the end of the fœtal life, and even during extra-uterine life. Retzius differs from other authors in believing that the gyrus uncinatus terminates at the bandlet of Giacomini, which, consequently, does not cross over the middle of the gyrus uncinatus. The so-called top of this gyrus belongs to the fascia dentata and the fornix, which expands here as a little cap and reaches the fascicle of Giacomini (the anterior inferior end of the gyrus dentatus). He calls particular attention to a small saccular formation discovered by him behind and in a distal direction from the infundibulum. This sac-like formation corresponds to the saccus vasculosus, which shows a high development in fishes, and which, he thinks, warrants its being denominated eminentia saccularis. On both sides of this are two protuberances, which he calls eminentiæ laterales, and corresponding to the lobi inferiores in fishes. These formations are distinctly developed in human fœtal brains, as well as in the brains of cats, dogs, sheep, reindeer, rabbits, etc., and in a less developed state in all brains, not only of the fœtus, but also of the adult.

Crystallized Digitaline as a Diuretic.—From the experience of EDGREN (*Hygiea*, vol. lvii, pp. 649–679) it appears that 0.001 gramme ($\frac{1}{64}$ grain) of crystallized digitaline administered in one dose possesses a cardiac regulating and diuretic action equal to or even greater than 200 to 300 grammes ($6\frac{1}{2}$ to $9\frac{1}{2}$ fluidounces) of the infusion of digitalis. These effects were always constant, although varying in degree according to the state of the patient. In no case did the drug cause symptoms of intoxication.

Clinical Notes and Lectures.

The Application of Forceps in Occipito-Posterior Positions.—In a clinical lecture PROFESSOR TARNIER, of Paris, speaks of the application of the forceps in cases in which the occiput of the fœtus, instead of being turned forward, is turned backward in the direction of the sacrum. He takes as an example the right occipito-posterior position. In order to clearly understand the manner of applying the forceps we must recollect that spontaneous delivery occurs in two ways: either the head turns, the occiput moving from right to left, in which case there is a complete rotation of the vertex and transformation of a posterior into an anterior presentation, or the occiput remains behind in the cavity of the sacrum, when, if the perineum is elastic and the uterine contractions violent, the head will disengage itself with the occiput turned backward, the posterior fontanelle first presenting at the vulva. In a case in which, on the contrary, the application of the forceps has become necessary, the delivery not having terminated spontaneously, *we must imitate the natural mechanism*, following all the movements which nature causes the head to make. He has long taught this rule and it has always proven a good one. The head may now either be turned forward or the occiput left turned backward. In the former case the movement of rotation is considerable. The instrument being applied, the head is brought forward in the pubis,—a mode of procedure which requires attention, there being now a great difference between the two presentations; while in the right occipito-anterior the rotation movement is slight and comparatively easy, in the right occipito-posterior it is much more considerable and its execution decidedly more difficult. Since the rotation movement is less extensive and more easily executed in the right occipito-anterior than in the right occipito-posterior, it is possible to transform the positions and turn the head by introducing the fingers into the uterus and applying them behind the ear. If this manœuvre succeed, delivery will take place spontaneously; in case it should not the forceps is applied, but under very favorable conditions now, for the operation has become very simple. If necessary, the head can be brought still farther forward. Prof. Flammeng, of Strasbourg, in 1816, gave precise indications concerning the method to be followed. In speaking of the right occipito-transverse presentation, Flammeng stated that before applying the forceps we may transform the presentation into a right occipito-anterior one by introducing the hand, seizing the head and causing it to turn in such a fashion as to bring the occiput forward, to the right: the head having been brought into position, the forceps is applied. The observations of this author have not been lost sight of and Prof. Tarnier has seen his preceptors proceed in this manner. The right branch of the forceps is guided upon the left hand, the instrument adjusted upon the head, and an effort made to cause it to turn. If successful the operation becomes much easier.

Given a posterior presentation, the first step is to turn the head according to the method of Flammeng and Loviat. In order to do this the left hand is introduced (in a right occipito-posterior presentation), which will be well placed for the application of the forceps, and the head caused to make a rotary movement from right to left and from behind forward. In this case the left hand presents a considerable advantage. Indeed, for the execution of the rotatory movement of which he speaks, the left hand will be found to be in pronation; that is to say, it will have made a movement by which it is enabled to exert the greatest force, while if the right hand had been introduced it would have had to execute a supination movement, which would have been decidedly weaker. If we were dealing with a left occipito-posterior presentation the right hand should be used, for the same reasons.

If the head can be turned the most difficult portion of the operation is accomplished, the application of the forceps being relatively easy. Now, having thus transformed the right occipito-posterior presentation into a right occipito-anterior one, the back, firmly held by the contracted uterus, remains in its former position; that is to say, it has not turned; consequently, if after having brought the head forward the hold upon it is released, it will return to its former position and the entire benefit of the manœuvre will have been lost. In order to keep the head in the position to which it has been brought *it is necessary to keep the fingers in place.* The right branch of the forceps is introduced with the right hand (it being well understood that all precautions have been taken, the bladder and rectum emptied), the blade being placed backward, then pushed upward in such a manner that it will come in contact with the side of the head. This will now hold the head in position, and the hand may be withdrawn, the branch of the forceps given to an assistant to hold firmly, without changing its position. The right hand is then applied on the left side and the blade introduced in a flat position as far as the sacro-iliac symphysis, and then, by means of Madame Lachapelle's movement, brought forward. Now, the branches of the forceps being in place, it becomes necessary to articulate them; but, as the left branch is situated above the right branch, it will be necessary to resort to what is termed the crossing of the branches and to cause the left branch to pass below the right, when the joining becomes an easy matter. Once the screw is tightened, it is only necessary to proceed with the extraction; having adjusted the retractor, and taking it in one hand, gentle traction is made upon it; the head descends and completes its rotatory movement. This is the mode of procedure to be adopted, when Flammeng and Laviot's manœuvre has been resorted to, before the application of the forceps.

In case the head remains back, either because Flammeng and Loviot's method has not been resorted to or because it has been unsuccessful, the forceps must be applied in a true right occipito-posterior presentation,—one branch of the forceps backward on the left side, the other in front on the right. It is of no special importance which blade is first introduced, but it is probably best to begin with the left. The two branches are to be introduced according to the directions already given and traction exerted if necessary. How to do this is an important and interesting question. We wish to turn the head with the instrument and to bring it forward in the pubis. This is an operation which succeeds admirably, but in order to have it thus succeed we must know what conditions must be complied with. The first is that the head must be flexed. If it is deflected rotation does not occur at all or it occurs very imperfectly; the head strikes the surrounding tissues and considerable injury may be inflicted. Consequently, the first thing to be considered is the flexion of the head. To obtain this one must pull upon the tractor; as the pelvis is somewhat funnel-shaped, the head in passing from the larger portion into the smaller portion naturally becomes flexed. In order to ascertain whether this has been accomplished the unemployed hand should be introduced to find the posterior fontanelle; if this is attainable the head is flexed; if, on the contrary, it remain above, the head is still deflected. Now, supposing that notwithstanding the pulling upon the tractor the head does not become flexed, the blades must be raised while pulling; this movement is transmitted to the head and it will become flexed. This result having been attained, the head must be turned, the occiput having remained turned backward. Professor Tarnier cannot sufficiently insist upon the movement to be executed in this case, the more so as he has seen errors committed by very expert obstetricians, which errors may give rise to very serious consequences. The forceps, being an elbowed instrument, its branches are made to rotate on a common centre, the blades in the interior of the genital organs will describe a large curve, and during this motion will strike against the surrounding tissues and perhaps produce tears. Consequently, in order that the head shall turn in the cavity without any friction, we must proceed in such a manner as to cause the blades to describe a small circle. In order to do this the *handles* of the forceps are made to describe a very large curve *while pulling*. This point is an important one. By means of this rotation movement all danger is avoided for the mothers and living children can be delivered. In many cases the occiput has hardly been brought forward below the pubis when the contractions become very violent and push out the head, which thus emerges too quickly. In this case it should be held back, either by the hand or by the forceps.

Professor Tarnier also speaks of another mode of operating. In order to apply the forceps it has been seen that the hand had to be deeply inserted, and that for each blade it was necessary to change the hand, left hand for the right branch, right hand for the left branch. It is readily conceived that a young primipara with a narrow vulva will suffer, and the question arises as to whether this suffering cannot be avoided by using the same hand for the introduction of both blades. This is possible and even easy of execution.

The forceps has now been applied, the rotation accomplished, and the occiput brought under the pubis. On looking at the instrument the concavity of the edges of the branches will be found turned backward and the forceps inverted. In order to free the head, where it does not itself become disengaged, it must be brought forward and upward. To make this movement, indispensable for its disengagement, the handles of the older forceps were raised, the ends of the blades lowered, and, touching the perineum, they traced two deep furrows, which sometimes resulted in tears. This was an extremely dangerous proceeding. Obstetricians long since noted this danger and have had recourse to the following means for its avoidance: The occiput having been brought below the pubis, the branches were withdrawn and again applied. Other operators endeavored to extract the head by seizing the forceps as near as possible to the blades. To-day neither of these methods are resorted to, and the head is extracted, with the concavity of the edges of the blades turned backward. To do this the tractor is raised while pulling upward and forward, and thus the ends of the blades no longer endanger the perineum. In this connection the forceps of Professor Tarnier are of great advantage.

When the perineum offers great resistance, and when the extraction is very difficult, it has been suggested that in diminishing the volume extraction would be facilitated, and with this end in view the branches of the forceps were withdrawn while waiting for delivery to take place alone.

This mode of procedure is evidently a good one, but it sometimes happens that the pains are lingering, the woman much fatigued, and that delivery does not take place. In this case resort must be had to a manœuvre described by Ritgen, which bears his name. The head being at the vulva and not emerging, a finger is introduced into the rectum, the wall of the rectum is then depressed, and by pressing upon the forehead through the rectal walls the disengagement of the head is facilitated. Although he has criticised this manœuvre in one of his works, Professor Tarnier acknowledges that he was wrong—at least, to a certain extent—in doing so. He has since made use of it to advantage in several cases, and would now rather recommend than decry it, as it may be of genuine service.

Some New Vaso-dilators.—In the recent Bradshaw lecture DR. BRADBURY has communicated the results of some valuable work on the nitrates derived from the higher valent alcohols, which serves to advance pharmacological knowledge and gives promise of adding to therapeutic resources. The discovery that nitrite of amyl ($C_5H_{11}NO_2$) dilates the vessels led to experiments which showed that the nitrites of the radicals of the monovalent alcohols generally have a similar influence on the vascular system ; and when it was pointed out that nitroglycerin, $C_3H_5(ONO_2)_3$, which so powerfully dilates vessels, is a nitrate of the radical of the trivalent alcohol glycerol, investigations were made which proved that the nitrates of the radicals of the monovalent alcohols act on the vessels like nitrites.

Dr. Bradbury's lecture advances our knowledge a step farther, for he demonstrates that the nitrates of the radicals of the divalent alcohol glycol, $C_2H_4(OH)_2$, of the tetravalent alcohol erythrol, $C_4H_6(OH)_4$, and of the hexavalent alcohol mannitol, $C_6H_8(OH)_6$, have the same vessel-dilating effects as the nitrates of the monovalent and trivalent alcohols. He points out that the action of some of the nitrates which he brings for the first time under notice is remarkably prolonged. Of the four which were specially investigated, methyl-nitrate seems to have lowered the tension of the pulse the longest time. In a patient to whom 10 minims (0.65 cubic centimetre) of this drug were given the tension remained low more than six hours. The dose in this case was a large one, and in experiments on animals he found the influence of methyl-nitrate in lowering blood-pressure less marked than that of the other nitrates. Glycol-dinitrate, $C_2H_4(ONO_2)_2$, is, like methyl-nitrate, a liquid. It was found to act like nitroglycerin when given in similar doses. Erythrol-tetranitrate, $C_4H_6(ONO_2)_4$, is a solid, melting at 60° C. (140° F.). Even in 1-grain (0.065 cubic centimetre) doses it was found to lower the pulse-tension for more than five hours, and this result was in keeping with experiments on animals, in which it lowered the blood-pressure more slowly, but for a much longer time, than nitroglycerin. Mannitol-hexanitrate, $C_6H_8(ONO_2)_6$, is likewise a solid, melting at 113° C. (240.6° F.). Its action is quite similar to that of erythrol-tetranitrate.

It seems probable that the nitrates of erythrol and mannitol may prove of considerable practical therapeutic value in many of those cases in which we now give nitroglycerin,—as, for example, cardiac pain, chronic Bright's disease, dyspnœa, and headache,—for they act for a longer time and they are quite as easily administered. They are but slightly soluble in water, but readily dissolve in alcohol and ether, and may be given either in the form of pills or tablets or in alcoholic solution.—*Medical Chronicle*, January, 1895.

Chlorosis.—M. Charrin, of Paris, in view of the fact that chlorosis occurs only in women and that some disturbance of menstruation is always present, expresses the opinion that the disease is due to menstrual or genital auto-intoxication. In fact, as menstruation is about to occur, the toxicity of the serum is increased; for instance, wet-nurses, in whom the menstrual function is preserved, often transmit diarrhœa and eruptions to the infants; at this time herpes and fever may also be observed. As soon as the flow begins, however, these symptoms—the headaches and muscular pains—disappear, the appetite returns, and all the signs of poisoning vanish. The author concludes that the menstrual function purges the economy of certain poisons, and that the genital organs play in this respect a rôle of elimination. Under the influence of heredity, scrofula, and tuberculosis this rôle, like that of other organs, is affected, and particularly so at the moment of puberty, when the demands on the organism are greatest and the accumulation of waste more rapid. At this epoch the imperfection of undeveloped cells becomes evident; the products of metabolism suddenly increase and are badly eliminated. This is, in itself, a first source of auto-intoxication. The narrowness of the arteries—especially of the mesenteric, which goes to the intestine, and of the pulmonary, which presides over gaseous nutrition—increases the faulty metabolism. To this general process of auto-intoxication is added another factor, that of obstruction of the genital depurative apparatus, and chlorosis results. Certain chlorotic patients, it is true, menstruate abundantly, but this does not form an argument against the genital theory of chlorosis, since there are patients with renal disease who excrete large quantities of urine. It must be ascertained in chlorosis if the blood contain poison, as it must be ascertained in polyuria if the urine is toxic.

M. Charrin believes that the causes advanced to explain chlorosis—such as poverty, overwork, emotion, etc.—are only occasional factors, the drop of water, as it were, which causes the glass to overflow, increasing the auto-intoxication by increasing the metabolism. Thus, all the morbid phenomena of the disease belong to the same category as those seen in experimental poisoning. The same is true of certain cardiac, digestive, nervous, and hepatic disturbances and of fever, all of which are often toxic in origin; fever, however, is met with generally in infection, as well as in nephritis, phlegmasia, and endocarditis, all of which have recently been noticed in chlorosis. The infectious agent would here naturally be sought for in the genital apparatus; but, on the one hand, these accidents are very rare; and, on the other hand, no parasite can be found. It is, therefore, plausible to explain it either by a chemical principle or by superadded bacteria.—*Gaz. hebd. de Méd. et de Chir.*, January 2, 1896.

Abarticular Gout.—Professor Jaccoud (*Semaine Méd.*, November 13, 1895) advises, in the treatment of this form of gout, a mixed diet, sobriety, and regular meals. He forbids truffles, shell-fish, sea-fish, pork, and game. If the gouty patient has the least tendency to obesity, farinaceous food is prohibited. As drinks, he advises pure water, light white wines well diluted with water, and light beers. Coffee and tea should be used with moderation.

If no improvement follow the use of this dietary for about fifteen days, as shown by urinalysis, drugs should be used after putting the patient on a partial milk diet. The author recommends the following: Lithium benzoate, 0.40 to 0.80 gramme (6 to 12 grains) in twenty-four hours, in pills of 0.10 gramme ($1\frac{3}{4}$ grains); after each pill a small quantity of alkaline mineral water. At the end of two weeks all medication is stopped for at least one week.

For slightly obese gouty patients, with the abdominal plethora of elderly persons, Carlsbad natural salts, 1 teaspoonful in half a glass of hot water, in the morning, for from eight to ten days. After an intermission of five or six days lithium salts may be given for ten days, after which the Carlsbad salts are recommenced.

Treatment at mineral springs is not advisable until at least two months after the last attack. When the gouty patient shows in addition symptoms of intestinal catarrh, flatulent dyspepsia, and a tendency to obesity, Carlsbad is preferable, the indication being absolute if the patient has had hepatic trouble. If there is only lithiasis, Jaccoud recommends Vichy; but if the patient is at all weakened, Vichy is contra-indicated, especially if there are cardiac troubles or symptoms of interstitial nephritis, no matter how slight. In the latter case less active, and therefore better tolerated, waters may be substituted, such as Royat or Ems. If the patient has tophi, waters richer in chloride of sodium, of which Wiesbaden is the type, should be chosen. If it is feared that these are too active, Baden-Baden or Hamburg may be tried.

All these waters are only useful in the prearticular or recent articular stages without tendency to cachexia. In the latter case they should be avoided and cold alkaline waters, such as Martigny-les-Bains, Contrexéville, Vittel, or Evian, used. Success, however, is not certain, for these waters only act when taken in large quantities (8 to 12 glasses in twenty-four hours), and, as they are cold, they are not easily tolerated.

Recent Suggestions in Therapeutics.

Formol in Urinary Therapeutics.—LAMARQUE has used *formol* in 1-per-cent. solution for washing out the bladder and urethra, and in 5-per-cent. solution for instillation in these localities. In acute gonorrhœa and in gonorrhœal cystitis the results have not been very encouraging; in the chronic gonorrhœa they have been better. It is particularly in cases of tuberculous cystitis that the treatment has been successful. The only disadvantage is the pain caused by the drug; this, however, though intense at first, quickly ceases. Daily washings with *formol solution* have been effectual in stopping hæmaturia, relieving pain, and lessening frequency of micturition in cases where every other treatment had failed. (*British Medical Journal*, January 11, 1896.)

Neuralgia.—DR. G. H. SEAGRAVE has for the last five years been in the habit of using hypodermatic injections of *cocaine* in lumbago, sciatica, pleurodynia, all forms of muscular rheumatism, and also for neuralgia of the head and face. For all, except neuralgia of the head and face, he injects from ¼ to ½ grain (0.015 to 0.03 gramme) over the seat of pain; for the two latter he injects into the arm. In a very large percentage of cases the result is most striking. The pain disappears almost entirely for some hours, to return in a much milder form. He continues the injections so long as the pain lasts. (*Provincial Medical Journal*, December, 1895.)

Oxygenated Water in Intra-uterine Hæmostasis.—M. PAUL PETIT calls attention to the triple property possessed by *oxygenated water* of hastening the precipitation of fibrin, of exciting the smooth fibres, and of injuring the tissues but slightly or not at all. For these reasons he concludes that it must be an excellent hæmostatic for external use. If, in a case of intra-uterine hæmorrhage due to fungous metritis or to interstitial fibroid, a tent covered with cotton dipped in *oxygenated water* at 12 volumes be introduced into the fundus an abundant moss will be seen to form, becoming confluent at the external orifice, while the organ contracts on the tent and the hæmorrhage is immediately arrested. There is no pain nor modification of tissues, and the hæmostasis persists long enough to enable the anæmic patient to recover strength and to support a radical operation later on if necessary. (*Lyon Médical*, January 5, 1896.)

Special Milk for Infants.—DR. EDMUND CAUTLEY, of London, has had a special milk for infants prepared by taking an equal quantity of mixed cows' milk and a 10-per-cent. solution of lactose, the whole being passed through a separator so arranged that the two outgoing streams are equal. It is thus divided into two equal parts, one of which contains practically the whole of the cream and may be termed *cream milk*, while the other contains practically no cream and may be termed *skimmed milk*. That the cream milk closely resembles human milk will be seen by the following table:—

	Cream Milk.	Human Milk.
Total solids, . .	13.11 per cent.	13.20 per cent.
Proteids, . .	1.82 "	2.00 "
Fats, . . .	4.02 "	4.00 "
Lactose, . .	6.88 "	7.00 "
Ash, . . .	0.39 "	0.20 "

The milk was well taken and digested by infants, but it was found that the percentage of fat was higher than some of them could digest, and this was reduced to 3.7 per cent. with excellent results. The milk is supplied in air-tight bottles and is previously Pasteurized at a temperature of 160° F. (71.1° C.). It is rendered faintly alkaline.

The advantages of a milk-supply of this nature are, according to the author, numerous and obvious. 1. By the process of separation a large number of deleterious substances which accidentally contaminate milk

—such as particles of manure, epidermal scales from the hands of the milker or the udder, hairs, dust, etc.—are removed. Needless to say, such constituents are very liable to be injurious to an infant. 2. By the process of Pasteurization the countless organisms present in milk are destroyed. It has been shown that a temperature of 160° F. (71.1° C.) destroys the bacilli of tubercle, typhoid fever, diphtheria, and many others. The liability of the transmission of disease to the infant by the milk supply is consequently abolished. 3. A substitute for human milk is supplied ready for use, and the trouble involved in the methods at present adopted is abolished.

An infant weighing 3000 grammes (=6½ pounds) would require of this milk during the first week 30 grammes (1 ounce); second week, 37 grammes (1¼ ounces); third week, 44 grammes (1½ ounces); fourth week, 51 grammes (1¾ ounces). During the second month the amount may be increased gradually by a quarter of an ounce a week, the total amounting to 3 ounces (93 grammes) by the end of the ninth week. From the age of nine weeks to six months from 3 to 4 ounces (93 to 125 grammes) are sufficient for a feed, and from six to nine months from 5 to 6 ounces (155 to 186 grammes) are enough. After the second month six or seven feeds may be given in the twenty-four hours at intervals of three hours. When the child is first put upon this milk it is advisable to give it diluted for a few days in order to gradually accustom the stomach to the change in diet. This is especially necessary in the case of children under three months of age, on account of the difference in the relative proportion of proteids from those of human milk. (*Lancet*, January 11, 1896.)

Sterilization of Catgut.—Saul, of Berlin, boils catgut in a mixture of *ethylic alcohol*, 85 parts; *carbolic acid*, 5 parts; and *water*, 10 parts, for five minutes at a temperature of 78° C. (172° F.). The addition of water is indispensable, as boiling in alcohol only does not insure complete sterilization, and especially in so short a time. (*Bull. Méd.*, January 1, 1896.)

Tannigen in Infantile Diarrhœa.—Moncorvo, of Rio Janeiro (*Bull. de l'Acad. de Méd.*, December 3, 1895), has used *tannigen* in twenty-one cases of intractable diarrhœa, usually malarial in origin, and in many cases complicated by hereditary syphilis or tuberculosis. It was easily administered in julep and invariably well borne. Its action was prompt, certain, and effectual, both in chronic and acute diarrhœa. In the presence of antiseptics, such as *salol*, *salicylate of bismuth*, etc., it lost none of its power, and Moncorvo strongly recommends the combination in cases where the fermentation processes in the large intestine are very active.

Ungual Tricophytosis.—*Iodine*, 1 gramme (15½ grains); *water*, 1000 grammes (1 quart); *iodide of potassium*, q. s. to dissolve iodine. Apply as permanent dressing. (Sabouraud, *Bull. Méd.*, January 12, 1896.)

Wounds.—Ceccherelli treats granulating wounds by dusting with equal parts of *iodoform* and *tannic acid*, finding this more satisfactory than a simple iodoform dressing. (*Riforma Med.*, October 19, 1895.)

New Books Received.

The editor acknowledges, with thanks, the receipt of the following books :—

PRINCIPLES OF SURGERY. By *N. Senn, M.D., Ph.D., LL.D.* Second edition. Thorougly revised. Illustrated with 178 wood-engravings and colored plates. Philadelphia : The F. A. Davis Company, Publishers, 1895.

A PRACTICAL TREATISE ON MATERIA MEDICA AND THERAPEUTICS, WITH ESPECIAL REFERENCE TO THE CLINICAL APPLICATION OF DRUGS. By *John V. Shoemaker, M D., LL.D.* Third edition. Thorougly revised. Philadelphia : The F. A. Davis Company, Publishers, 1895.

A PICTORIAL ATLAS OF SKIN DISEASES AND SYPHILITIC AFFECTIONS IN PHOTO-LITHOCHROMES, FROM MODELS IN THE MUSEUM OF THE ST. LOUIS HOSPITAL, PARIS, WITH EXPLANATORY WOOD-CUTS AND TEXT. By *Ernest Besnier, A. Fournier, Tenneson, Hallopeau, du Castel, Henri Feulard, Léon Jacquet.* Edited and annotated by *J. J. Pringle, M.B., F.R.C.P.* Rebman Publishing Company, Limited, London, 1895.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs :—

Three Cases of Laryngeal Neoplasm. by **Charles H. Knight**, New York.——Treatment of Pelvic Pus Cases by Abdominal Section, by **J. Wesley Bovee**, Washington, D. C., 1895.——Vaginal Hysterectomy by the Clamp Method, by **Sherwood Dunn**, Los Angeles, Cal., 1895.——Treatment of Typhoid Fever by Intestinal Asepsis, by **A. L. Benedict**, Buffalo, N. Y., 1895.——Some Points in Regard to Sterilization in Private Dwellings, by **Carl Beck**, 1895.——Two Cases of Ruptured Tubal Pregnancy, by **J. Wesley Bovee**, Washington, D. C., 1895.——Peut-on Liver de la Forme du Crane de Conclusions sur les dispositions Anatomiques rendant plus ou moins dangereuses les operations sur le rocher ? par **P. Garnault**, Paris, 1896.——Rational Treatment of Pertussis, by **Francis T. B. Fest**, Plank Road, Mich., 1895.——Auscultatory Percussion and Allied Methods of Physical Diagnosis, by **A. L. Benedict**, Buffalo, N. Y., 1895.——Tubercular Laryngitis, by **Charles H. Knight**, New York.——Adenoids in the Naso-Pharynx, by **Charles H. Knight**, New York ——A Case of Renal Calculus, by **Augustus A. Eshner**, Philadelphia, 1895.——Fibroma of the Nasal Fossa, by **Charles H. Knight**, New York, 1895.——Diminutive Liver from an Infant, by **A. A. Eshner**, Philadelphia, 1895.——Congenital Malformation of the Heart, by **A. A. Eshner**, Philadelphia, 1895.——Report of Some Unusual Cases of Fracture and their Treatment. by **Walter Courtney**, Brainerd, Minn., 1895.——Technics of Maunsell's Method of Intestinal Anastomosis, by **F. W. Wiggin**, New York, 1895.——Sarcoma of the Larynx, by **John A. Thompson**, Cincinnati, Ohio, 1895.——Sur un cas d'hémorragi réflexe post-operatoire de la caisse du tympan, chez le pigeon, par **P. Garnault**, Paris, 1895.——De la mobilisation profonde et de extraction de l'étrier comme moyens de traitment des surdités dues a des lesions localisées dans l'oreille moyenne. par **P. Garnault**, Paris, 1895.——Annual Report of the Supervising Surgeon-General of the Marine-Hospital Service of the United States, for the Fiscal Years 1893 and 1894, by **Walter Wyman**, Washington, D. C.——Differential Diagnosis between Localized Neuritis, Rheumatism, and Some Other Conditions that give Similar Symptoms, by **L. F. Bishop**, New York, 1895.——Review of the Present State of Our Knowledge of Gout and a Discussion of its Comparative Frequency in America, by **L. F. Bishop**, New York, 1895.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

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ANÆMIA.

In a monograph reprinted from the *New York Medical Journal*, December 7, 1895, on this subject now before us, we find much food for thought and much information to guide the conscientious physician in treating successfully those suffering from anæmia, which we find in all classes and conditions of the human family. Geo. D. Barney, M.D., House Physician to the Winyah Sanitarium, Asheville, N. C. (formerly of Brooklyn, N. Y.), in this excellent monograph covers the subject very fully.

He first classifies anæmia, gives its etiology, exciting causes, symptomatology. On examining the blood taken from anæmic patients we find the hæmoglobin diminished and, as the disease progresses, the corpuscles growing less. He then takes one through anæmia in all its phases and shows us what the post-mortem knife reveals, examining each organ in the order of its importance. He then takes up *seriatim* the various means used to combat anæmia and cure, and in summing up claims that the administration of iron produces results the most brilliant. In giving iron, up to the present time, difficulties almost and apparently insurmountable have been met. He then takes up the various forms of iron treatment. We quote: " Since I am of the opinion that iron is our sheet-anchor in the treatment of anæmia, and since all preparations hitherto used have been inefficient or have presented certain disadvantages, I now come to a consideration of a preparation which, I am convinced, will revolutionize the treatment of anæmia. Dr. Gude, of Leipzig, Germany, has perfected a preparation which, while retaining all the therapeutic effects of iron, presents none of its disadvantages." " It is a solution of manganese-iron-peptone, neutral in reaction; agreeable, non-astringent, and mildly aromatic in taste; miscible with wine or milk." He then gives cases in which cures were effected. Again we quote from this valuable monograph: " In concluding, I might add that, in the medical treatment of anæmia, also chlorosis, we find a specific in the combination of iron and manganese as prepared by Dr. A. Gude, and I congratulate him upon the excellence of the preparation, as it has proved a most efficient and valuable one."

PHENOCOLL.

In a lengthy article, entitled " Contribution to the Study of the Antimalarial Action of Phenocoll," by Dr. Gino Righi, of Padua, and published in the *Rassegna Medica*, the author concludes:—

" The results attained with the new remedy are, therefore, most encouraging, and lead to the following conclusions:—

" 1. Phenocoll hydrochloride is an antimalarial remedy equal, or more than equal, in efficacy to quinine, and can be prescribed with confidence.

" 2. It not only overcomes the febrile temperature of malarial patients, but it reduces the enlargements of the spleen and the evil consequences arising from it.

" 3. Its action is most pronounced when administered in small doses every hour for five hours previous to the expected return of the febrile access.

" 4. It is innocuous to the organism, and no undesirable symptoms or disturbances arise even from continued administration daily.

" 5. Its taste is only slightly bitter and can be easily corrected; so that it is readily taken by children."

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Selections from Society Proceedings.

BELGIUM.

Société Royale des Sciences Médicales et Naturelles, Brussels.

Resection of the Hip in Coxalgia.—Dr. A. Lambotte, of Antwerp, in a comprehensive monograph, presented 12 personal cases of resection, 11 successful, and gave a full history of tuberculous disease of the hip-joint and the measures employed for its cure. (*Annales*, tome iv, fasc. 3.) He stated that even the partisans of conservative measures agree that their results are far from brilliant. Among them, Bruns, of Tübingen, from an experience of 600 cases, recognizes that the method has serious inconveniences. The mortality, according to him, is 40 per cent.; the length of time required for treatment averages four years, the orthopædic results are sometimes very bad, and the restoration of function is never perfect. A similar confession from surgeons whose experience and dexterity cannot be questioned proves that resection of the hip gives even worse results. Yet resection has proved wonderfully efficacious in other joints, as the elbow, shoulder, and even the knee. What is the cause of the inferior results in hip-joint disease? Does the tuberculosis act differently from the tuberculosis of other articulations? Such a supposition is contrary to all pathological and clinical knowledge of the disease. Practice has sufficiently demonstrated that a solid and almost perfect articulation as regards function may be reproduced after operation. On the other hand, the objection to resection of the hip cannot be explained by the seriousness of the operation, for it is seldom followed by death when practiced according to the rules of modern surgery. Of 48 resections of the hip, Volkmann had only 4 deaths; Grosch, from a study of 166 cases, finds that resection practiced at the beginning of the suppuration is attended by no mortality. Dr.

Lambotte expressed the opinion that the operation can therefore only have been abandoned on account of the persistence of suppuration, fistulæ, and the mediocre orthopædic results obtained. He formulated the following conclusions: 1. Conservative measures should be reserved for the first stage of coxalgia. 2. Surgical intervention is indicated as soon as pus forms in the articulation. 3. In non-suppurating coxalgia intervention is indicated if the pain and deformity prove rebellious to treatment by continuous extension. 4. A bloody operation is never contra-indicated by the extent of the local lesions. 5. Disarticulation of the hip should never be practiced at the outset. 6. The best method for total resection is the longitudinal external incision. 7. Vertical division of the trochanter is very useful as the first stage of the resection. 8. In the child the cartilaginous trochanter should always be preserved intact. 9. The danger of resection, when practiced at the beginning of suppuration, is almost *nil.* 10. Resection is the less serious as it is the more radical. 11. In order to insure complete and definite cicatrization all the tuberculous tissue must be extirpated. 12. In suppurating coxalgia resection gives better functional results than the conservative method. 13. Mobile nearthrosis after resection is better than ankylosis. 14. Extensive resections of the acetabulum have no value from an orthopædic point of view. 15. In the child subtrochanteric resection with preservation of the trochanteric cartilage gives orthopædic results identical to those of simple cervical section.

FRANCE.

SOCIÉTÉ FRANÇAISE D'ELECTROTHÉRAPIE.

Hysterical Polyuria Cured by Electricity.—M. JULES GRAND related a case of polyuria in a woman, 42 years of age, manifestly hysterical, with pharyngeal anæsthesia, anorexia, complete insomnia for nine months, cutaneous hyperæsthesia, disturbance of tactile sensation, and contraction of the visual field. The polyuria had progressively increased from its gradual appearance some nine months previously and the patient passed from six to eight litres (quarts) of urine daily. The amount of fluid ingested was above the normal, but less than the quantity of urine excreted. The body-weight had diminished twenty pounds in ten months and the emaciation was extreme. Treatment consisted in the use of electricity of high tension, a machine with a large platform on which the patient was seated being employed, and friction over the clothing with a metallic electrode for two or three minutes, together with an electric breeze, being used. The sittings were twenty in number, lasting from twenty to thirty minutes. After ten sittings the quantity of urine fell to one and one-half litres (three pints) and never afterward rose beyond this amount. Improvement took place rapidly, sleep, appetite, and strength returning to the normal. The weight increased from 106 to 120 pounds in three months. The cure persisted, but the hysterical symptoms, though improved, did not disappear. Dr. Grand asked whether it could be claimed that the polyuria in this case was hysterical, because it had developed in a patient suffering from hysteria. Such varied disturbances are observed in this affection that there is a tendency to attribute all of them to hysteria, when they are sometimes simply coincident. In the speaker's case certain elements necessary to prove the hysterical nature of the polyuria were lacking. The evolution of the symptom might have been modified by hypnotic suggestion, but the patient refused. The gradual onset is contrary to what occurs in polyuria of alcoholic origin, which appears suddenly after excesses at table or too copious libations; while its definite disappearance under treatment, when the other stigmata persisted or re-appeared after having been more or less influenced, is also against an hysterical causation. In spite of the close relationship between the polyuria and hysteria, the case is of interest as showing the possibility of the independent evolution, side by side, of the two affections.

The influence of electricity in restoring nutrition in so debilitated a patient is not surprising to those familiar with electrotherapy, which has a constant effect in heredity or acquired diuretic conditions dependent on some deviation from physiological nutrition.

M. Apostoli stated that, while electricity would not cure hysteria, it would certainly act upon the symptoms of hysteria. In this respect it was a sovereign remedy, principally when used in the static form. He did not doubt the hysterical nature of the polyuria in Dr. Grand's patient, the rapidity of cure being the chief reason for this belief.

Dr. Grand stated that suggestion had played no rôle in the cure, since the patient attached little or no importance to the polyuria, being much more pre-occupied with the other symptoms from which she suffered.—*Presse Méd.*, January 25, 1896.

Société de Thérapeutique.

Theobromine in Renal and Cardiac Disease.—Professor Huchard, of Paris, gave the details of fifteen cases under his care at the Hôpital Necker in which he used this drug, and stated that numerous observations warranted him in asserting that theobromine is one of the best and most reliable and constant of diuretics in the treatment of anasarca or œdema associated with affections of the heart or kidneys. It is a direct diuretic, acting at once on the renal epithelium, exciting and increasing the function of the latter without altering it. Theobromine is especially effective in cases in which there is both cardiac and renal sclerosis. in valvular disease complicated with albuminuria, or at the stage of asystole, and in interstitial or parenchymatous nephritis. The diuretic effect of the drug is not increased by combining it with digitaline and caffeine or with lactose. In order to prolong the effect it is advisable, especially in cardiac disease, to give theobromine for six days, and to follow up the last dose in a few days by 0.0005 to 0.001 gramme ($\frac{1}{130}$ to $\frac{1}{64}$ grain) of digitaline for one day. The diuresis caused by theobromine is rapid, occurring on the first day of its administration and persisting from two to four days after the last dose.

There are no cumulative effects, more than 3 grammes (46 grains) producing, in certain persons, headache, nausea, and vomiting, but rarely cerebral excitement. An average dose is from 2 to 3 grammes (31 to 46 grains) in wafers containing 0.50 gramme (7¾ grains). Larger doses, 4 to 5 grammes (1 to 1¼ drachms), are without danger and are often employed. In infectious diseases in which the elimination of urine is of great importance, as well as in severe forms of hepatic disease in which the hepatic cells are involved, milk diet combined with theobromine, in daily doses of 2 to 3 grammes (31 to 46 grains), produces excellent results by insuring and increasing diuresis.—*Bull. Gén. dé Thér.*, January 23, 1895.

Société Médicale des Hôpitaux.

Sero-therapy per Rectum.—M. Chantemesse called attention to the fact that in the early days of sero-therapy the method was only utilized in the treatment of diseases (diphtheria and tetanus) where the specific germ does not exist, or exists only exceptionally, in the blood of the patient. The only inconvenience of the subcutaneous injection was a slight pain, some erythema, or urticaria. Of late the method has become generalized, and is employed more and more to combat diseases characterized by the presence in the blood of the specific micro-organisms. In these cases the serum injected is, as a rule, unirritating. In certain rare instances, however, the part chosen for the injection becomes the seat of intolerable pain, much swelling, and even abscess. M. Chantemesse has satisfied himself that these complications are not due to the impurity of the serum, but to an afflux to the part of a crowd of leucocytes filled with germs. The resulting abscess is endogenous in origin. He has seen such abscesses develop after the injection of antistreptococcous serum. In order to obviate these inconveniences M. Chantemesse has in twenty cases injected the serum into the bowel. He states that absorption is thus easy, and exempt from the inconveniences above mentioned. The bowel is first washed out with an ordinary water enema, and the serum is then introduced through a gum-elastic catheter twenty centimetres long attached to a syringe. It is claimed for the rectal method that it is as efficacious as the ordinary or subcutaneous, the same feeling of *bien-être*, the same fall of temperature, etc., occurring in one as in the other. Is the protective power of a dose of serum absorbed by the intestinal mucous membrane equal to that of the same dose introduced into the areolar tissue? M. Chantemesse is inclined to answer in the affirmative, but he suggests the advisability of further researches on this head. In cases of serious erysipelas he has, without any inconvenience whatever to the sufferer, injected into the bowel in a few days as much as 200 or 300 cubic centimetres (6½ to 9½ ounces) of serum. A local application of great value in erysipelas is serum mixed with five times its weight of lanolin. The pain, redness, and swelling are quickly reduced by this ointment. Roux's serum employed as an enema in three cases determined results as satisfactory as when administered in the ordinary way.—*Lancet*, February 8, 1896.

GREAT BRITAIN.

Society of Anæsthetists, London.

Nitrous-Oxide Anæsthesia.—Dr. T. Sydney Short, of Birmingham, read a paper entitled "Observations on a Series of 550 Timed Nitrous-Oxide Cases." Complete records had been kept of 553 cases attending the Birmingham Dental Hospital; of these, 436 were females and 117 males, showing a proportion of 4 to 1. Their ages varied from 6 to 59 years, the average age of the whole series being 22.5 years. The first part of the paper dealt with cases in which nitrous oxide was given alone. There were 411 of these,—308 females and 103 males. The average length of the inhalation period of these cases was 49.4 seconds, and of the anæsthetic period 41.9 seconds. The males gave a longer period both of inhalation and anæsthesia,—viz., 50.7 and 42.6 seconds, as compared with 48.3 and 41.3 seconds for the females. In 25 children of both sexes below 13 years of age the average inhalation period was 41.7 seconds, and the anæsthetic period 33.3 seconds, the average anæsthesia of the boys being 2 seconds longer than that of the girls. The second part dealt with administrations of nitrous oxide mixed with air. Among the 553 cases there were 142 of these,—128 females and 14 males. The average inhalation period was 50.5 seconds, and the anæsthesia 48.3 seconds. Here the anæsthesia of the females exceeded that of the males by 2 seconds, being 48.3 as against 46.6. Of children under 13 years of age 17 took the gas with air; the boys had an average advantage over the girls of 1.5 seconds in the anæsthetic period. Fourteen patients of the whole series were over 45 years of age, and their average anæsthesia exceeded that of the serial average by 5 seconds, showing that the length of anæsthesia may be expected to increase with age. In every period of life it was shown that when gas was administered alone males gave a longer anæsthesia than females.

Mr. Woodhouse Braine commented upon the low average of the number of teeth extracted,—3 for so long an average period of anæsthesia as 42 seconds. In his opinion the only true test for timing anæsthesia was the reaction to the application of pain; he did not consider the patient to be in an anæsthetic state because he did not lift an arm or open his eyes when told to do so.

Dr. Dudley Buxton said that his experience of giving nitrous-oxide gas mixed with air was quite at variance with that of Dr. Short as far as jactitation was concerned. He found that air introduced into the system in proper proportion completely prevented jactitation.

Dr. Hewitt confessed that it was often very difficult to say when anæsthesia actually terminated, and for this reason he thought it hazardous to attach too much value to timed observations. He had found that the admission of but a small quantity of air during the inhalation of nitrous oxide invariably prolonged the inhalation period.

Dr. Silk said that it was almost impossible to fix upon any one sign as an indication of recovery, as there appeared to be in each case a variable period during which the patient was semiconscious and incapable of resenting even painful impressions.

Dr. Maughan said that in dental cases it was a matter of common experience for a patient to cry out while the first tooth was being extracted, but to remain perfectly still and motionless during the rest of the operation. He found that the return of sensibility to pain and the moment when the surgeon should cease operating were coincident with the return of the reaction of the iris to light.

Dr. Short, in reply, said that he had been surprised to find that the inhalation periods of the administrations of gas and gas with air corresponded so nearly; but there was no doubt that in the method adopted—that of giving a full breath of air at intervals—this was his actual experience, as proved by his figures. The occurrence of jactitation when air was admitted in this way had unquestionably been the case, and he could only suggest that the particular gas used might have influenced the character of the anæsthesia. The greatest number of teeth extracted during one administration of the gas was thirteen; the somewhat low average of extractions was probably due to the fact that it was becoming the custom for so many patients to take the gas for the removal of only one or two teeth. He had not come across any cases of metrorrhagia or renal trouble ascribed to the inhalation of the gas.—*Lancet*, February 1, 1896.

RUSSIA.

Pædiatric Society of Moscow.

Pseudobulbar Paralysis in Infancy.—Kyssele reported a case of pseudobulbar paralysis in a female child 3 years of age, born healthy, the only anomaly being pronounced flexion of the fingers and toes. Very soon after birth the parents noticed that the child nursed imperfectly and that the tongue was never protruded. With this exception she developed normally. When about twelve months old she had an acute disease, lasting about three months and diagnosed as typhus. This illness was followed by great weakness, and the difficulty of deglutition became more pronounced. The child has never spoken.

On examination it was seen that the tongue could be moved only with great difficulty; there were copious salivation and an unpleasant odor from the mouth. The bones and muscles were well developed; there were no traces of rachitis; nutrition was poor; the mucous membranes normal in color; the gums were swollen, hyperæmic, and bled easily. The internal organs were healthy, hearing and sight normal. A non atrophic simple paresis of the two lower branches of the facial nerve also existed, especially pronounced in the orbicularis muscle of the mouth. The child could not retain food or make a blowing movement.

The upper branches of the facial nerve were normal, but the hypoglossal nerve was paralyzed on both sides. The muscular contraction of the facial nerve was quite normal, respiration free, but phonation was disturbed. The extremities were very rigid, but the electrical reaction was preserved.

Cutaneous and tendon reflexes were exaggerated, especially in the lower extremities. The feet were in a position of equino-varus. The child could stand upright if supported. but was absolutely unable to walk. She suffered from occasional incontinence of the urine. Appetite was good. These symptoms, according to the author, indicate bulbar disturbance, with diplegia of the extremities, but without atrophy or change in muscular contractibility. It was thus not a case of true bulbar paralysis, but a pseudoparalysis resembling Berger's congenital paralysis.

Mouratoff confirmed Kyssele's diagnosis, and thought that the pseudoparalysis had some connection with the acute disease from which the child suffered when a year old. Though the condition was incurable, he advised section of the tendo Achillis to allow the child to walk.

Masked Malarial Fever.—Vermele described some cases of masked malarial fever, under which name he includes all atypical forms, as diarrhœa, cough, headache, neuralgia, or convulsions, but always retaining its characteristic appearance, periodicity, intermittence, and rapid disappearance of the symptoms. According to Vermele, it is especially in the form of intestinal affections that malaria manifests itself in children, and he has seen thirty-one cases of this kind.

In one case, that of a child 5 years of age, an attack of malarial fever occurred in April, 1891. In May of the same year the child had diarrhœa which lasted until October, and which resisted all treatment. During the winter of 1895 there were fresh attacks of malarial fever, followed in the succeeding summer by diarrhœa, appearing from 11 A.M to 5 P.M.; liquid stools, slightly colored with blood and containing mucus; abdomen slightly swollen; right iliac region painful; spleen perceptible on palpation. The diarrhœa rapidly disappeared on the administration of quinine three hours before the attack. A week after the cessation of the diarrhœa there was a characteristic attack of malaria, which also yielded to quinine.

In the case of a breast-fed infant of 6 months diarrhœa appeared without any apparent cause, there being five or six stools daily. After the exhibition of calomel on the first day of the affection the diarrhœa became periodical,—three stools between 8 and 9 A.M. and two during the day. The spleen was not enlarged. Cure was obtained by the use of two doses of quinine, 0.30 gramme ($4\frac{1}{2}$ grains) each. The other cases were all almost identical and were all in children from 1 to 10 years of age.

Alexandroff remarked that these cases did not afford an entirely convincing proof of the author's assertions, since examination of the blood had not been made.

Guippius stated that he had often met with this malarial diarrhœa, which rapidly yielded to quinine.

Replying to several objections made to his conclusions, Vermele asserted that the rapid and certain action of quinine was sufficient proof that the cases were true malarial diarrhœas, and, although in a few cases there was a rise of temperature and increase in the size of the spleen, the diarrhœa was always the most pronounced symptom. He considered all these cases, therefore, as marked malarial fever.

Angina in Diseases of Remote Organs.—Hippius discussed the etiological value of angina in affections of distant organs, and cited the case of a child, 10 years of age, that had been under his observation for seven years. The patient has never had any cardiac disturbance, but had had dysentery at the age of 3 and attacks of malaria between 5 and 8 years. Since then its general health had been good. During the night of May 16th angina appeared, lasting two days, with pulse of 100. The day following fever developed, with pulse of 120; it was found that the tonsils were swollen, and auscultation revealed a slight systolic murmur, distinct at the base. The temperature soon fell, but the murmur at the base became more marked. About July it commenced to decrease in intensity and finally disappeared. Hippius believed that, in this case, there was a close connection between the endocarditis and the follicular angina from which the child was suffering.

Dreyer questioned whether the murmur might not be related to some affection of the cardiac muscle, the probability of which Hippius admitted.

Kyssele thought that in all cases of endocarditis, the origin of which is not clearly established, rheumatism should first be thought of, as it sometimes causes trifling disturbances, but may, in some cases, attack the heart directly.

Surgical Society of Moscow.

Fixation of the Liver.—Bobroff described the case of a woman, 50 years of age, who had suffered for twenty years from attacks of pain in the right side, and who, from time to time, showed signs of icterus which could not be accounted for. Two years ago the liver increased in volume, following a traumatism and strain. When examined by him it was the thickness of two fingers above its normal limit, and extended to a hand's breadth below the umbilicus, to the iliac bone. The patient experienced difficulty in walking, and was unable to sit down or to lie on the left side without suffering great pain. Bobroff decided to perform hepatopexy. Incision of the wall showed the liver to be normal in appearance, but adherent to the large omentum, which contained an apparently healthy vesicle. Fixation was effected by two strong silk threads; the first passed through the entire thickness of the liver by means of two needles crossing at points four centimetres apart and was fastened to the ninth rib. The second thread passed through the liver perpendicularly to the first, and the two ends were fastened above the same rib, which in this manner served as a kind of traction pulley. The surface of the liver was scraped with the point of a needle to induce secondary adhesions with the diaphragm, and the wound was closed. No operative sequelæ were noticed.

For a few weeks, when taking deep inspirations, the patient felt the rib drawn downward, but at the end of three months this inconvenience ceased, and, although the icterus returned, the pains were definitely cured. A year later the liver was still in the same position, being only two fingers' breadth beyond the costal edge.

SWITZERLAND.

Société Médicale de Genève.

Curetting After Abortion.—Dr. Ch. Patru, one of the surgeons to the Geneva Maternity, read a paper on this subject, expressing the opinion that the curette was not sufficiently used in cases of abortion, many surgeons preferring the expectant plan, unless there is serious infection or profuse hæmorrhage. He himself believed in early intervention, to prevent complications, rather than to combat them when they did appear. He has used the curette in 211 cases at the maternity,—134 times for abortion and 77 times for chronic metritis. The hæmostatic effect in abortion was immediate, the flow of blood ceasing as soon as the uterine cavity was relieved of its contents. In these cases the hæmorrhage should serve as a guide to the operator, who should continue curetting until all flow has stopped, or, in other words, until the last of the *débris* has been eliminated. When the operation is complete, the lochia will be slight and insignificant. Dr. Patru obtained such a result in 62 cases in his private practice, while at the clinic, where students without great experience are often obliged to operate in emergency cases, he found it necessary in 20 out of 72 cases to practice a complementary curetting the following day, in order to complete the emptying of the uterus. In none of these cases, however, did death from hæmorrhage occur, which demonstrates that curetting can always master such hæmorrhage, provided it be done thoroughly,—an important point when it is remembered that hæmorrhage constitutes one of the greatest dangers of miscarriage. In 50 cases with fever the temperature returned to normal more or less rapidly in 44, while in the rest the infection went on to a fatal termination; 5 of these 6 patients had submitted to attempts at procuring abortion, and were in an alarming condition when intervention was undertaken.

Anæsthesia is contra-indicated in almost all cases of abortion in which curetting is done, not only because the pain is moderate and of short duration, but also because it is dangerous to give an anæsthetic to a woman who has been suffering from severe hæmorrhages.

Dr. Patru prefers the sharp ring-curette of Sims, the angle of the ring with the handle of 140 degrees to 150 degrees. As the extremity is rounded, and the elbow formed by the ring and the handle, the curette presses obliquely on the tissues, and with ordinary care perforation of the uterus need not be feared. Simple prudence dictates, naturally, that, as long as the uterine muscle remains in a state of atony, the curette should be used with gentleness, gradually becoming more vigorous as the walls harden and the cavity contracts about the instrument.

UNITED STATES.

Society of the Alumni of Charity Hospital, New York.

Digital Examination in the Diagnosis and Treatment of Diseases of the Throat and Nose.—Dr. S. Kohn, in a paper on this subject, spoke of the importance of diagnosis in the practice of medicine. Clinically, palpation and digital examination have been considered of the highest importance in physical diagnosis. While inspection ranked first, palpation was a close second, since it revealed characteristics which the eye could not see. The general practitioner has neglected digital examination in diseases of the throat and nose, and Dr. Kohn wished to emphasize its importance. He advised supplementing instrumental examination by a careful palpation of the parts, after thoroughly disinfecting the hand, introducing the index finger to the posterior pharyngeal wall, cautiously palpating the tonsils and perhaps the naso-pharyngeal space and upper larynx, and feeling certain changes which the eye could not see. The change visible to the eye was a change in conformation, such as that of enlarged tonsils and that of tuberculous swelling of the epiglottis or of the arytenoid cartilages, while the index finger could feel whether the tonsil was made up of dense organized connective tissue or of soft granulation tissue. This would afford information as to the method of abscission to be followed, whether with the guillotine or with the snare, as in the hard connective-tissue tonsil the danger from hæmorrhage following the operation with the amygdalotome was greater than that following the use of the cold snare or the cautery loop. Again, the eye would detect a swelling running along the border of the posterior faucial pillar: the index finger would feel that this swelling was hard and unyielding, pointing to the diagnosis of possible incipient malignant disease; and implication of the submaxillary lymphatics, discoverable by palpation, made the diagnosis a certainty. While a tense, glazed, protuberant swelling seen upon the posterior pharyngeal wall of a child would lead to the supposition of retropharyngeal abscess, the detection of *fluctuation* by the index finger would leave no room for doubt as to the diagnosis. Cleanliness was the first requisite to a proper digital examination of the throat; gentleness of manipulation was the second, and a thorough knowledge of the normal topography and feel of the parts the third. Digital examination was of value in adenoid vegetations, where a rhinoscopical examination was often impossible. If the mass were soft, pulpy, and easily crushed, it could, perhaps, be removed by crushing and scraping with the finger-nail at the time of examination. If the child were enveloped in a strong band of toweling, imprisoning both upper extremities, and held sitting upright upon the lap of a nurse, the entire operation could be completed in a few moments without narcosis, with or without instruments. Digital examination was invaluable in detecting malignant disease of the throat, as careful palpation with the index finger would reveal induration, raising the question of malignancy, which would be settled by a microscopical examination. In follicular amygdalitis it was also of great value. Foreign bodies were often felt by the finger when they could not be seen by the eye. In diseases of the nose the tactile sense had not such a wide field of application. The author spoke of a case of rhinolith which the index finger had succeeded in dislodging after all instruments had failed. In the Asch operation for deflection of the nasal septum the index finger was introduced into the nostril on the side of the convexity of the septum, and pushed the fractured septum over to the other side, after which the splints were introduced.

Dr. D. Bryson Delavan thought palpation an exceedingly valuable aid in many cases, but said that it should never supplant the laryngoscope or other instruments of precision. Palpation in a nasal cavity was seldom applicable. In the retronasal space it was a valuable aid; yet even here it was not well to subject the patient to it if the rhinoscopical mirror could be used. The employment of digital examination should be cautiously entered upon, and the physician should be careful not to inflict pain in examining acute lesions. Regarding the use of anæsthetics in the removal of adenoids, the Germans almost invariably operated without an anæsthetic, the French sometimes did and sometimes did not, and the English, practically, always employed one. The speaker considered the English idea the right one; not only was it humane, but one could obtain more perfect results in the thorough removal of the offending tissue. Palpation was valuable in the diagnosis of malignant growths and foreign bodies, and no expert man should be without a thorough knowledge of it. It ought not, however, to take the place of instruments.

Dr. Proben said that in small children quicker results were obtained from digital examinations, as in the case of retropharyngeal abscess. In the case of intubation the only means was to use the finger for the introduction and to see if the tube were in position; but its greatest value was in diseases of the naso-pharynx in children. Anæsthesia should be employed in an operation for adenoids, and the forceps, the curette, and the finger-nail be used. He showed a specimen of adenoids which he had removed two weeks before. The child had had a fetid rhinitis. The trouble had existed for three weeks and the speaker examined the patient for adenoids. He felt a peculiar body in the naso-pharynx, which, on being removed, proved to be the peel of an apple, calcified, measuring about four by two inches. After removing that, he had put the patient under the influence of chloroform and removed the adenoids. The presence of this foreign body in the naso-pharynx of so small a child, and its long retention, made this case unique and interesting.

Dr. Kohn said that he was aware that there was in his paper nothing new to a specialist, but that his object had been to impress the importance of a digital examination on the general practitioner. He did not wish to have it take the place of instruments. Less pain was caused the child by the introduction of a finger than by the use of instruments, and in adenoids the finger gave much information that was indispensable to an operation. Regarding the use of anæsthetics, he believed a much more perfect operation could be done under chloroform anæsthesia, but in dispensary practice it was almost impossible. The method he had described was very rapid and effective.—*New York Medical Journal*, January 4, 1896.

Medical Society of the State of New York.

Technique of the Improved Cæsarian Section.—Dr. H. J. Garrigues, of New York, read a paper with this title. He said that, if possible, the operation should be performed toward the end of pregnancy, but before the beginning of labor. Four assistants are desirable, and the strictest antiseptic precautions are taken. The bowels and bladder are emptied, the vulva shaved and cleansed, and the vagina thoroughly disinfected by the free use of tincture of green soap and of sublimate irrigation. The instruments are sterilized by heat. The patient should be in the dorsal position. The operator should satisfy himself by percussion that no knuckle of intestine lies in front of the uterus. The incision is made in the median line, half above and half below the umbilicus, just enough to admit of turning out the uterus,—about six or seven inches. The right hand is now introduced into the abdominal cavity and used to turn out the uterus, seizing it in the region of the left cornu. The upper part of the incision is closed with three or four silk sutures, one inch apart and going through the whole wall. A rubber tube is placed loosely around the cervix and broad ligament, and crossed, but not tied, the uterus being enveloped in a sterilized hot cloth, and dry pads placed front and behind with gutta-percha tissue. The elastic constrictor is now tightened, and the uterus incised in the median line and the bleeding sinuses clamped. The left index finger is then inserted and the incision extended with scissors or probe-pointed bistoury, carefully avoiding the lower uterine segment, where there are large veins and much less contraction than in the body of the organ. This incision should be four to five and one-half inches in length. If the placenta be inserted on the anterior wall, the incision is carried through. If the waters have not broken, the operator tears the ovum on its anterior surface; if the ovum have already ruptured, the head of the child is, if possible, delivered first, so as to prevent the danger of the uterus contracting in front of it. If this be not easily done, the operator seizes an extremity and pulls the child out of the uterus. The cord is tied immediately with a double ligature and then is cut between the ligatures. If the placenta be still adherent, it is to be left alone while the uterine sutures are inserted. If it still remain adherent, the placenta is to be peeled off with the membranes. If the operation has been performed before dilatation of the cervix, this should now be effected manually in order to secure free drainage. For the deep sutures No. 4 silk should be used, and No. 2 for the superficial ones. The deep sutures should be inserted, half an inch from the edge, through the peritoneal and muscular layers. It is better to keep the peritoneum outside of the muscular layer. The superficial sutures should be inserted through the peritoneal layer, half an inch from the edge, in such a way as to apply broad surfaces to each other. After the removal of the placenta the interior of the uterus is simply wiped dry and the clots removed. No antiseptics are needed, and the uterus should not be curetted. After the tying of all ligatures the elastic constrictor should be very gradually loosened. After all hæmorrhage has ceased the uterus is replaced and the abdominal wound closed as after other laparotomies. The wound is dusted with iodoform, and dressed with iodoform gauze, gutta-percha tissue, sterilized gauze, and absorbent cotton held in place by broad strips of adhesive plaster and a many-tailed bandage. The bowels are moved on the third day and the antiseptic dressing is changed in a week. The sutures are removed on the eighth day. The patient is allowed up at the end of three weeks. As a rule, the speaker said, the appendages should not be removed, as repeated Cæsarian section gave even a better prognosis than the first operation. The speaker closed with the statement that when he had done his first operation he had not been aware that either Leopold or Sänger had done this operation.

Dr. W. Gill Wylie opened the general discussion. It was better, in his opinion, to have 10 per cent. of ventral hernia and 25 per cent. remain in bed for many weeks, than to have an increase of 1 per cent. in the mortality and a quicker convalescence. In his 105 vaginal operations he had had good results and only one fatality, but this he explained by the fact that 75 per cent. were selected cases,—mostly cancer. The vaginal operation did not seem to him to admit of such thorough surgery or such accurate diagnosis as was possible by the abdominal operation.

Dr. Herman J. Boldt, of New York, said that total extirpation of the pelvic organs should only be done when there were recurrent pelvic inflammations and abscesses. In these cases ligatures were entirely out of the question, for the uterus is too high and too firmly fixed. It was not necessary to leave the clamps longer than twenty-four hours. It seemed to him very bad surgery to operate upon cases of carcinomatous uteri in which it was impossible to operate in healthy tissue.

Dr. M. D. Mann, speaking of operations on the intestine, said that while he had had fair success with the Murphy button, he preferred intestinal suture. He was in the habit of taking four stitches of continuous suture at a time, then interrupting it and tying it. This method was both safe and time-saving. Regarding vaginal hysterectomy, he expressed his admiration for this operation, though the great danger of intestinal fistula fully compensated for the ventral hernia claimed as a serious objection to the abdominal operation.

Dr. W. G. Macdonald, of Albany, said that instead of pulling down the uterus he preferred to pass a hook around the broad ligament and pull it down. The ligament thus broadened and thickened could be readily grasped by a specially devised forceps or clamp.

Dr. A. H. Goelet, of New York, thought that the popularity of vaginal hysterectomy depended entirely upon its novelty. For the vaginal operation it was claimed that the shock was less, the convalescence quicker, and that there was freedom from an abdominal scar. On the other hand, perfect asepsis was difficult to secure, the operation was liable to be incomplete, the field of operation was limited, the viscera and the ureters were more liable to be injured, the hæmorrhage was more difficult to control, diagnosis was not so easy as by the abdominal route, there was greater danger of fistula, and extensive adhesions more often rendered this operation impossible than in the case of abdominal section.

Dr. J. Riddle Goffe, of New York, said that, if the ovaries and tubes were hopelessly diseased, the uterus was no longer of use and had better be removed. This did not add to the mortality. He had met with two recent cases in which the appendages had been removed through Douglas's pouch and the uterus left behind. These patients had come to him shortly after operation with symptoms of infection, and examination had shown the uterus in each case to be full of pus. The use of clamps or ligatures he regarded as largely a matter of individual choice.

Dr. A. T. Bristow said that in urgent cases, as one of strangulated hernia, the time occupied in operating seemed to him to be all important. All the methods of direct suture required the utmost expertness and consumed much time,—two objections which did not apply to methods in which mechanical aids were employed.—*American Medico-Surgical Bulletin*, February 1, 1896.

Medical Society of the District of Columbia.

Nephritis of the Newborn.—Prof. A. Jacobi, of New York, delivered an address on this subject, which he summarizes as follows: Nephritis is a frequent disease of infancy and childhood and by no means very rare in the newly born. What was formerly considered mere albuminuria, or a transient form of it, we have been taught by improved methods of investigation, mainly by the use of the centrifuge, to recognize as nephritis. A predisposition to nephritis in the young is caused by the fragility of the blood-vessels in the newly born; by the relative imperviousness of the young renal capillaries compared with the large size of the renal arteries; by the feebleness of the young intestinal muscle, which proves insufficient to expel toxic contents; by the extensiveness and size of the young intestinal blood-vessels and lymphatics, and the large size of the villi,—all of which favor the absorption of toxins.

From an etiological point of view, nephritis in the newly born may be: 1. *Congestive* (from feeble circulation, congenital heart disease, asphyxia, or exposure to low temperatures). 2. *Obstructive* (from the physiological rapid decomposition of the blood of the newly born; the formation of hæmatoidin=bilirubin; jaundice; the production of methæmoglobin by chemical poisons, such as potassic chlorate, or by excessive heat; or the presence of blood in the uriniferous tubes). 3. *Irritative* (from the presence of uric-acid infarctions or hæmatoidin infarctions, of purpuric or other interstitial hæmorrhages, or of microbes and toxins in the numerous eruptive and infectious maladies and in enteritis).—*New York Med. Jour.*, January 18, 1896.

Quinsy.—The local application of *cocaine* in acute parenchymatous tonsillitis was recommended by Dr. de Havilland Hall in 1888. (*Trans. Clinical Society of London*, vol. xxi, p. 234.)

R. Hingston Fox has repeatedly tested the value of the methods, and claims that a strong solution of *hydrochlorate of cocaine* freely applied to the affected tonsil early after the onset of an attack of true quinsy (the form which commences on one side of the fauces,—peritonsillar inflammation tending to suppuration) will in most cases cut short the attack, and suppuration will not occur.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

Dr. F. Levison,

Referent for den Dansk Litteratur vedrörende: Almindelig Medicinsk Pathologi og Therapi, deri indbefattet, Nerve- og Sindssygdomme, Pädiatrik, Obstetrik, Gynäkologi, Hygieine, Demographi, Retsmedicin, Pathologisk, Anatomi, Bakteriologi.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

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Hepatic Disease without Urobilinuria.—Faber (*Hospitals-Tidende*, p. 1269, 1895) relates the case of a man, 37 years of age, suffering from diarrhœa and intermittent fever (highest temperature, 39–40°; lowest, 35–36° C.). No icterus and no enlargement of the liver was observed. In the course of some months general anæmia developed, some of the veins of the abdomen became obstructed by thrombi, the inferior extremities became œdematous, and the patient suddenly succumbed. At the autopsy a suppurating echinococcous cyst was found in the right half of the liver, and there were thrombosis of the vena cava and embolus of the left pulmonary artery. Microscopical examination of the liver showed cirrhosis and angiocholitis. During life urobilin had never been found in the urine, as it had not in some other cases of liver disease examined by the author; on the other hand, patients without disease of the liver sometimes presented urobilinuria. Faber is consequently disposed to doubt the correctness of the French theory that urobilin is the pigment of the diseased liver-cell. He feels more inclined to adopt the German theory, that bilirubin alone is secreted by the liver, healthy or diseased, and that this coloring matter is reduced in the intestine into urobilin, which passes into the urine only by absorption from the bowels.

Peritoneal Myxoma in the Male.—Hertz (*Hospitals Tidende*, p. 1042, 1895) relates a case of peritoneal myxoma, or pseudomyxoma, in a man 75 years of age. The abdomen was much enlarged and six large herniæ were found (inguinal, crural, umbilical, and epigastric). Only a few drops of a gelatinous fluid were obtained by puncture. At autopsy 9 to 10 litres of a greenish jelly-like substance were evacuated, the masses in many places being adherent to the peritoneum, which was everywhere thickened, opaque, and whitish. Several semisolid tumors the size and shape of an egg contained cysts filled by the jelly. No echinococcous cyst could be found. Microscopical examination showed that the disease was produced by a proliferation of the endothelium of the peritoneum with consequent formation of cysts and of a myxomatous exudate. Only a few cases of this rare disease could be found in literature by the author, and these cases were all in females.

Perforation of Stomach and Duodenum.—Blume (*Nordskt medicinskt Arkiv*, No. 21, 1895) compares the mortality of cases of perforation of the stomach or duodenum treated by operation or medically. Of 27 cases observed in the hospitals of Copenhagen and treated without operation 7 recovered; of 17 cases treated by operation 6 recovered. In the operative cases the seat of the perforation occurred 3 times in the pyloric region or duodenum (1 recovery), once on the posterior wall of the stomach (recovery), 4 times on the anterior wall (1 recovery), and 9 times in the cardiac region (3 recoveries).

Inflammation of Bartholin's Gland.—R. BERGH (*Hospitals-Tidende*, p. 1095, 1895) considers this affection in married women, and states that in healthy individuals these glands and their duct cannot be perceived by palpation. Inflammation is most frequently caused by gonorrhœal infection, one out of seven or eight cases of gonorrhœa being thus complicated. The affection occurs somewhat more frequently on the left side than on the right (943 to 741). Catarrhal inflammation of the glands may also be seen, but much more rarely, the percentage being about 20. Simultaneous infection with gonococci and other bacteria has also been observed. In 41 to 45 per cent. of the cases the pus has a bad odor. The inguinal glands are rarely observed to be enlarged and tender in this disease, Bergh having only seen this condition 13 times in 1251 cases.

Anomaly of the Heart.—ROSING-HAUSEN (*Hospitals-Tidende*, p. 977, 1895) describes the case of a child which from birth presented a cyanotic color of the face, especially when crying. Death occurred after five months. At autopsy the ventricles as well as the auricles of the heart were found freely communicating; the aorta originated from the right ventricle and communicated through the open duct of Botallo with a vessel that was regarded as the pulmonary artery, although it was very slender and thin-walled.

Madeira as a Health Resort for Consumptives.—BANG (*Bibliothek for Läger*, p. 497, 1895), who has lived for eight months in Madeira, describes this reputed health resort for phthisical patients. The changes of temperature are not great, but the air is constantly loaded with humidity and is always moved by strong winds. There are no hygienic arrangements, either general or special, adapted for phthisical patients. There is not on the whole island a single veranda or covered place in the open air where the patients may find shelter against the wind and showers.

Congenital Occlusion of the Œsophagus.—HIRSCHSPRUNG (*Hospitals-Tidende*, pp. 1037, 1199, 1895) describes accurately two cases of congenital occlusion and one case of congenital stricture of the œsophagus. In both cases of occlusion the upper portion of the œsophagus ended in an enlarged and rounded *cul-de-sac*, while the inferior portion communicated with the trachea.

Diagnosis of Diphtheria.— FIBIGER (*Hospitals-Tidende*, p. 1173, 1895) discusses the difficulties of diagnosing diphtheria by the aid of cultures. He finds that the platinum thread is not suitable for obtaining cultures from the throat of the patient, sterile cotton-wool twisted about a copper wire being preferable. Much care must be taken to sterilize the serum; if this be not properly done, or if saprophytes from the throat have been brought away with the diphtheria bacilli, the former will soon outgrow and completely cover the colonies of the latter. The cultures may be sterile when antiseptic gargles have been employed; sometimes the bacilli may even be dead in the membranes without any treatment; while, at the same time, cultures from the larynx or the trachea may prove their presence in full vigor.

Antitoxin in Diphtheria.—BRUUN (*Bibliothek for Läger*, p. 486, 1895), having lost 6 out of 17 patients from diphtheria, adopted the antitoxin treatment, with the result that, of 73 patients, only 3 died. As an especially fortunate case is mentioned one of a child, 3 weeks of age, suffering from a diphtheritic sore on the umbilicus, acquired from a fatal case of diphtheria. After the injection of 10 cubic centimetres (2½ drachms) of serum from the Pasteur Institute the infant recovered.

Norway.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÆDIATRIK, OBSTETRIK, GYNÄKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

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Tuberculosis in Norway.—ANDVORD (*Norsk Mag. f. Lägevidenskaben*, p. 1013, 1895) has collected statistics bearing on the frequency and distribution of tuberculosis in Norway. He includes in his figures not only cases of tuberculosis of the lungs, but also of the bones, glands, and meninges. It appears that below the age of 15 years only a third of the cases are of pulmonary tuberculosis, the balance being of meningitis or scrofulosis. Undoubted signs of tuberculosis are rarely noted before the age of 6 weeks in cases coming to autopsy, but in the second half of the first year of life the disease is more frequent than at any other age. This is not only true in Norway, but has also been noted at Helsingfors, Kiel, Brussels, the towns of Denmark, and many other places. There is a minimum frequency between the ages of 10 and 15 years, and a second maximum between the ages of 30 and 60 years. The author finds that tuberculosis is so wide-spread in Norway as to affect from 1 to 6 per 1000 inhabitants. It is almost as frequently observed in the country as in towns.

Beriberi.—ROLL (*Norsk Mag. f. Lägevidenskaben*, p. 929, 1895) observed a case of beriberi in a sailor who had contracted the disease in Java while his vessel stopped at Batavia to take on water. After two months on the sea seven out of eighteen men were attacked with beriberi, three dying. When Roll saw his patient, convalescence had set in. He presented irregular heart-action, dicrotic pulse, œdema, and anæsthesia of the lower limbs. Recovery was complete in three months. Examination of the blood and bacteriological cultures gave only a negative result.

Appendicitis.—RAMM (*Norsk Mag. f. Lägevidenskaben*, p. 917, 1895) believes that appendicitis consists most frequently of incarceration of the appendix from sudden distension of the cæcum. He bases this belief on the researches of Busch and Kocher, and upon a certain number of cases observed by himself, one of which was remarkable. A man of 55 years suffered for six months from pain in the ileo-cæcal region, and from diarrhœa, dying with symptoms of intestinal perforation. Autopsy revealed the presence of a chip of wood three centimetres long implanted in the walls of the appendix. Another case was that of a tuberculous young man whose appendix measured fourteen centimetres in length. It was normal in appearance, but distended in the lower portion, and contained 4 or 5 grammes (1 or 1¼ drachms) of mercury administered by a quack eleven weeks before his death.

Diphtheria Antitoxin.—Smith (*Norsk Mag. f. Lägevidenskaben*, p. 809, 1895) publishes seventy-seven cases of diphtheria occurring in his practice in a rural district and treated by Behring's antitoxin. The mortality was 4.2 per cent., whereas it had been 22 per cent. on an average during the preceding eight years. The remedy seemed especially to influence the general condition, while paralyses were not much affected.

Clinical Notes and Lectures.

The Spleen in Infectious Diseases.—In a contribution to the study of this subject F. Bezançon (*Thèse de Paris*, 1895) states that infections induce in the spleen two kinds of alteration, the first direct structural changes less the effect of a lesion than of functional hyperactivity. In this class must be placed hypertrophy of the Malpighian corpuscles, direct or indirect multiplication of lymphocytes or their transformation into mono- or poly- nuclear leucocytes, and proliferation of the elements of the pulp. In the second kind of alteration there are true lesions, especially of a degenerative nature, involving the corpuscle as well as the pulp, and causing necrosis of cells or areas of cells. These lesions are preceded by the appearance in the pulp and blood-capillaries of large mononuclear or macrophagous leucocytes containing in their protoplasm products of cellular degeneration, as, for instance, small leucocytes, nuclear *débris*, hæmatins, and pigment. This may be seen in varying degrees in all local and general infections, bacteria being absent in the former and present in the latter, where they form colonies in the pulp, free or inclosed in phagocytes. From these lesions the rôle of the spleen in defending the organism against infection may easily be deduced, though no precise points can be obtained by experimental pathology and the study of animals deprived of the spleen. The objective study of the human spleen at various stages of infections shows much more plainly its protective influence. The great predominance of phenomena of leucocytic proliferation over direct local phagocytosis demonstrates that the organ in infectious diseases serves less to destroy the bacteria on the spot than to produce defensive elements to be carried to and utilized in the parts of the economy affected by the infectious process. The want of knowledge on the semeiology of the spleen, entirely limited to splenic hypertrophy, makes it easy to understand why this evolution is obscure. This symptom, however, is of so much value that it frequently constitutes a decisive argument in favor of an infectious syndroma.

Apoplexy of the Pancreas.—SARFERT discusses the cause and mechanism of death in apoplexy of the pancreas, three cases of which have come under his observation (*Deut. Zeit. f. Chir.*, B. xlii, H. 1 and 2, 1895). The etiology of the affection is obscure, syphilis, alcoholism, obesity, and arterio-sclerosis having been advanced as possible causes, without, however, any indication as to the manner in which these varying lesions could end in apoplexy of the pancreas. Two of Sarfert's patients were addicted to alcohol. As regards the mechanism of death in these cases, he believes that there is a reflex action on the heart, as well as an auto-intoxication by intestinal products. Basing his theory upon the experiments of Hildebrand and Jung, he claims that the pancreatic juice acts directly upon the intestine, causing lesions—such as congestion, ecchymoses, etc.—which favor the absorption of toxins and permit the passage of bacteria through the walls of the intestines. In two cases in which he made a bacteriological examination of the fluid exudation into the peritoneum the author found coli bacilli in one and chains of micrococci in the other. Auto-intoxication generally occurs in subacute cases, and here laparotomy may be of value, guided by the formation of a tumor in the epigastric region and the presence of sugar in the urine, as noted in several cases. Sarfert believes that in acute cases, however, surgical intervention is useless, as exact diagnosis is almost impossible.

Pneumonotomy.—PODRES performed pneumonotomy in a case of gangrene of the lung in which the expectoration had been abundant and fetid for two years (*Jour. des Prat.*, November 16, 1895). The lesions had primarily been in the right lung, but the patient had recovered spontaneously, the communication of the diseased portion with the bronchi having been sufficient to expel the dead tissues. The same accident, but more severe, followed in the left lung, with fever and expectoration, the latter being as much as 300 or 400 cubic centimetres (9½ or 12¾ ounces) in twenty-four hours. The case being considered serious, Podres operated under ether, making an incision 12 centimetres long from above downward in the left subclavicular region. Having separated the periosteum of the second and third ribs, he excised pieces 3 centimetres long. The parietal layers of the pleura not being adherent in the upper portion of the incision, he sutured them, and, having made a transverse incision of the lung, from which issued a considerable quantity of exceedingly fetid pus with pulmonary *débris*, he curetted the walls of the cavity, washed it out with a 1½- to 1-per-cent. solution of phenol and boric acid, and tamponed with iodoform gauze. After the third dressing the pus had lost its fetid character and diminished in quantity. The wound healed in three weeks, and forty-five days after operation the patient had gained 14 kilogrammes (31 pounds) in weight.

The Blood in General Diseases.—MONTI (*Archiv für Kinderheilkunde*, B. xiii, H. 3, 4, 1895) states that in children the specific gravity of the blood increases in certain febrile diseases; it increases during the inflammatory stage of pneumonia and diminishes after the crisis; during the acute stage of intermittent fever it also increases, to fall slowly and gradually when the fever has ceased. It increases in pleurisy during the entire febrile period. In pulmonary tuberculosis the specific gravity is normal when there is no fever and the general condition is good; it diminishes, on the contrary, when this is not the case. It diminishes in various forms of anæmia, nephritis, and chorea. In cases of mild chlorosis the relation between the specific gravity and the quantity of hæmoglobin is modified, the former being normal, but the latter diminished. In diseases of long duration, as tuberculosis, giving rise to great organic combustion, the specific gravity increases while the hæmoglobin diminishes. In acute nephritis the specific gravity diminishes and the hæmoglobin remains nearly normal, while in severe chlorosis, leukæmia, and pernicious anæmia both specific gravity and hæmoglobin decrease, though there is no close relation between the respective changes.

Empyema in Children.—SCHUTZ, of Hamburg (*Jahrb. d. Hamb. Staatskr.* vol. xiii, p. 260), has within the past three years treated eighteen cases of empyema in children, the majority being metapneumonic cases following influenza. Two patients under 1 year succumbed, but the other sixteen recovered, almost all without any thoracic deformity. The author recommends operation as soon as a diagnosis can be made in these cases, as delayed operation may be followed by dangerous after-effects. The best operation, and the only one to be recommended in childhood, is, in his opinion, costal resection. The dangers of chloroform are less in the child than in the adult, the former being more tolerant of the drug, while a stronger heart enables him to overcome the disturbance caused by empyema in the lesser circulation and also the sudden removal of the exudate. Treatment by siphon drainage is not favorably regarded by him, for the reason that children, being restless, are liable to pull out the drains, allowing air to penetrate into the pleura and the wound to become infected. In operating Schütz advises circumscribing of the inferior and posterior borders of the healthy lung and resecting, on the diseased side, the rib situated two or three centimetres above this limit, near the vertebral column.

Vomiting in the Diagnosis of Scarlet Fever.—The diagnosis of eruptive fevers at the onset is often so delicate, especially in light forms, that it is useful to report the slightest symptoms. VALLI-ATTILIO (*Gaz. d'Osped.*, No. 129, 1895) especially notes the occurrence of vomiting entirely different from that observed in other eruptive fevers. This vomiting occurs very early, before any other morbid manifestation, and, in the absence of any previous gastric trouble, it surprises the child in the midst of play and before the appearance of headache, malaise, fever, or initial angina. In a number of cases of scarlet fever without exanthema the diagnosis was decided solely by the vomiting and the angina following it. The proof that this symptom belongs to the scarlet fever and not to an ordinary angina is that several cases of angina where it existed were complicated with nephritis, and that children subject to recurrent angina never vomited until the day they had scarlet fever and its characteristic angina.

Perforation of the Aorta by a Bony Outgrowth from the Sixth Rib.—A remarkable and uncommon cause of death was disclosed at a post-mortem examination recently made by DR. E. A. LIGHTBURNE, of London (*Lancet*, January 11, 1896), on the body of a boy, aged 12 years, who had died very suddenly without any previous illness. All the organs were perfectly healthy with the exception of a small portion of the left lung lying over the neck of the sixth rib on the left side. Further examination showed that a bony outgrowth from two to three inches in length sprang from the anterior surface of the sixth rib, at a point between the neck and the tuberosity. This spicule had penetrated the lung and the thoracic aorta, causing almost instant death by hæmorrhage into the left pleura. The outgrowth was very firmly attached to the rib and had the appearance of having been there since birth. At the spot where the lung had been pierced there was hardening of the tissue, but no sign of abscess.

Early Signs of Intestinal Perforation.—PROF. A. L. GLUZINSKI, of Cracow, has observed two signs which enable the physician to diagnose the occurrence of intestinal perforation before peritonitis has had time to manifest itself (*Semaine Méd.*, November 6, 1895). The first of these signs consists in the distinctness with which the murmurs of the heart and respiration can be heard by auscultation of the abdomen, a phenomenon due to the presence of intestinal gases in the peritoneal cavity. The second and more important sign is the change in the pulse, which, at the moment of perforation, becomes accelerated, to slacken some hours later. This phenomenon, due to the absorption of putrid gases acting like a cardiac poison, is, besides its diagnostic significance, of importance, from a surgical point of view, as indicating the most opportune moment for operation.

The Objects and Limits of Operation for Cancer.—In the Lettsomian Lectures for 1896 W. WATSON CHEYNE, of London, discusses operations in cancer, by which term he understands the carcinomata, the essential feature of which is continuous and excessive growth of epithelium. The primary object of operation in cancer is, of course, the prolongation of the patient's life and the alleviation of his local trouble, and Mr. Cheyne asserts that these results are in most cases best attained by aiming, wherever it is possible, at the cure of the disease. Until quite recently, and even now, many surgeons approach operation in these cases impressed with the view that real cure is practically hopeless, and that with few rare exceptions the most that can be expected is prolongation of life for a variable length of time. They, therefore, oppose elaborate and extensive operations which in themselves must involve considerable risk to life, and are content with fairly free removal of noticeable disease; in some cases, indeed, they do not even go so far. Mr. Cheyne, however, strongly urges the view that the first question to be kept before us in investigating a case of cancer is whether there is any possibility of curing the disease or not. Such a point of view makes a great difference in the operation, for it is not then sufficient to remove only noticeable disease, but it is necessary to take away as far as possible the parts in which disease may have become disseminated, although still unrecognizable,—in other words, possibly infected lymphatic areas. Thus, if the skin is affected, a considerable portion around must be taken away, and this is the more necessary where the infection of the skin has come from beneath,—as, for example, where cancers of the breast reach the surface,—for the dissemination in the cutaneous lymphatic plexus is often under these circumstances very rapid and extensive, and this is probably due in part to the larger size of the deep cutaneous plexus, which will, in the latter case, be first involved. Again, where muscle is infected, the cancer-cells are very rapidly and early driven along the lymphatic vessels of the muscle, and, even though there only may be one visible nodule in the muscle, the whole or the greater part of it must be looked on as suspicious and must be removed if there is to be anything like certainty in attaining the object of the operation,—namely, the patient's cure. Again, as regards the lymphatic glands, we know that from a very early period they become affected, and that, of course, without any visible enlargement in the first instance, and, in addition to this infection of the glands without enlargement, plugs of cancer-cells very often stick in the lymphatic vessels on their way to the glands. Hence it is necessary in all cases where the disease has lasted any time, or extended at all deeply, not only to remove the primary mass freely, but also to take away the whole lymphatic area up to and including the nearest lymphatic glands. Thus, the operation performed with the object of curing the disease becomes a much more extensive one, and consequently much more serious than that which simply aims at getting rid of the main trouble for a time and prolonging the patient's life.

The limits of the radical operation are where there is no reasonable prospect of removing the whole disease, or where, together with a very poor prospect of success, there is a very high mortality from the attempt. In such cases operation should not be considered at all.

But, even in cases where hope of cure or marked prolongation of life by a radical operation is out of the question, operation may sometimes be advisable with the object of removing symptoms which are immediately threatening to life,—such operations, for example, as tracheotomy, colotomy, etc.; or, in the second place, with the object of taking away the primary disease from a part, such as the mouth or throat, where its continued development means intense pain and trouble, and thus of substituting for these troubles an easier death from exhaustion. A *sine quâ non* of such operations must, however, be that they are reasonably free from immediate risk; and, with regard to the second class, that there is a prospect of attaining the object of the operation,—namely, the entire removal of the disease from the part operated on. Mr. Cheyne does not think that a dangerous operation is allowable for simple relief of symptoms, however proper it may be, if a cure may be hoped for.

There are thus two different objects to be held in view, and two different questions as regards operation which we must bear in mind in treating a case of cancer,—namely, (1) can we reasonably hope for a cure? for, if we can, a serious or dangerous operation is permissible; or (2) cure not being possible, can we decidedly ameliorate the patient's condition by operation, such operation, however, not involving any great risk of life?

As regards the limits of operation for cure in breast cancer, therefore, the author would exclude from operation (1) cases of cancer *en cuirasse;* (2) cases in which there is a large mass in the axilla involving the nerves; (3) cases in which large glands can be felt above the clavicle; (4) all cases in which secondary cancers already exist elsewhere.

In none of these instances is there any reasonable prospect of cure, and there will be but little to be gained by subjecting the patient to the elaborate operations to which he has referred. Short of these conditions, however, he thinks that the patient ought to have the chance of operation.

While the results of intervention are steadily improving, the proportion of cases which succumb to cancer is still considerable, and will not be much reduced till patients and doctors understand that there is a good chance of radical cure from early and thorough operation in mammary cancer, and that a suspicious lump in the breast, especially in elderly women, is not a thing to be watched, for over 90 per cent. of the swellings of the breast in elderly women are cancerous.

Mr. Cheyne gives the following statistics of breast operations by different surgeons:—

OPERATOR.	Total Cases.	Mortality.	Known Recurrences or Deaths from Metastases	Cures	CASES DONE MORE THAN THREE YEARS BEFORE THE REPORT.				No of Cases Cured.
					Total.	Mortality.	Recurrences, or Metastatic Deposits	Cures.	
		Per ct.	Per ct.	Perct		Per ct	Per ct.	Per ct.	
Fischer, Henry	147	20	55	8	86	22	59	15	13
Esmarch, Oldekop	229	10	44	10	171	13	(?)	14	25
Before 1863	. .	. .	. .	. .	47	. .	. .	4	2
After 1863	. .	. .	. .	. .	124	. .	. .	18	23
Rose, Fischer	61	26.3	(?)	6		. .	. .	. .	4
Billroth, Winiwarter	143	23.7	62	5	89	22	68	9	8
Trendelenburg, Neuendorff	97	11	54	2	50	12	68	4	2
Lücke, Dietrich	110	7.6	(?)	9	69	8	60	13	9
Czerny, Schmidt	150	4.4	(?)	5	82	6	46	8.5	8
Kronlein, Horner	144	4	58	18	121	4	68	20	25
Küster, Schmidt	222	10.8	(?)	9	132	14	(?)	15	20
Konig, Hildebrand	135	. .	. .	17	118	9	61	20	23
Bergmann, Eichel	114	4.3	62	11	43	7	62	30	13
Mitchell Banks	82	12	26.8	21.9	. .	. .	. .	. .	18
Halsted	50	. .	43	4 or 8	11	. .	54	18 or 36	2 or 4
Watson Cheyne	61	1.6	31	19.9	21	. .	42.8	57	12

Contrary to the usual dictum, it is now found that the most favorable of all cases for operation are those of atrophic scirrhus, and the more nearly a cancer approaches the atrophic form the greater is the chance of permanent cure. Cheyne believes that the malignancy of the cancer in the individual cases has a great deal to do with the favorable result of operation, more than the early period of the operation; but that, expressed in other terms, is only to say that in the less malignant forms of cancer the disease does not diffuse itself as rapidly or widely, and that by an extensive operation we have a better chance of getting beyond it. A patient with a small tumor which has been noticed for several months, which has not markedly increased in size, and in connection with which there are only small glands in the axilla, has a much better chance than one who has found a tumor quite recently which is noticeably enlarging, and in which the axillary glands are of considerable size. In the former case the probability of getting beyond the disease is great on account of its slow spread; in the latter the reverse is the case. Hence, while the sooner a cancer of the breast is radically removed the better, one cannot say that the chance of cure is necessarily proportionate to the early period of the operation; in any case, however, the chance of cure of necessity depends on the thoroughness of the operation.—*British Medical Journal*, February 15, 1896.

Statistics of Cataract Extraction.—The results of English surgeons in the extraction of cataract are embodied in a paper by Dr. C. Devereux Marshall (Royal London Ophthalmic Hospital Reports), who gives details of 1519 cases, in which the operation of extraction was performed during the five years 1889–1893 inclusive; and, as these cases occurred in the practice of eleven different surgeons, some of whom performed one operation and some another, the personal element can be entirely excluded. The combined operation of extraction with iridectomy is the one most frequently performed at the Royal London Ophthalmic Hospital at Moorfields; and of the total number, 1091 were done by this method as against 276 in which the simple extraction was performed; while 161 had an iridectomy done some weeks at least before the cataract was removed. Attention, however, is called to the fact that those cases in which no iridectomy was done were, as a rule, picked cases, and that any in which obvious disease existed usually had iridectomy performed either as a preliminary operation or at the time of the extraction.

The following are the results, including as successful cases all those whose vision ranges between $\frac{6}{6}$ and $\frac{6}{60}$: 1. Extraction without iridectomy, 91.97 per cent. 2. Extraction with iridectomy done at the same time, 89.81 per cent. 3. Extraction after preliminary iridectomy, 87.29 per cent.

It is fully recognized that the great risk of extracting by the first or simple method is the liability that exists for prolapse of the iris to occur, and, the more peripheral the section, the greater is the chance of this happening. In 13.86 per cent. of the cases this actually occurred, as against 0.87 per cent. after iridectomy had been done.

The percentage of successful cases, as defined above, only amounted to 83.78, and 13.51 had no useful vision. Of all the 1519 cases the percentage of enucleation after extraction amounted to 1.90. Another point of interest brought out in the paper is that of the secondary complications which occur after extraction and after needling. Although the latter is, as a rule, such a simple procedure, yet many cases subsequently do badly. One of the most serious complications, glaucoma, occurred in 2.08 per cent. of the cases after secondary operations on the capsule, while it occurred in only 0.42 per cent. of cases after extraction. Black or darkly-colored cataracts are usually associated with myopia; this was found in 51.51 per cent., and the results recorded confirm the prevalent view that they do not succeed nearly so well as ordinary cases. A black cataract is usually associated with some diseased condition of the eye.

Pseudocoxalgia.—In a clinical lecture at the Hôtel-Dieu, Paris, PROF. S. DUPLAY (*Sem. Méd.*, December 18, 1895) divides pseudocoxalgia into two principal classes. In the first he ranges cases in which the coxo-femoral articulation is healthy or in which a lesion exists in its neighborhood. In the second class he places the more interesting form in which not only is the joint itself intact, but in which there is no lesion in the more or less immediate vicinity. Cases in the first group differ essentially, but most frequently there is some inflammation of the bony structure, either of the pelvis or the upper end of the femur, and principally at the level of the great trochanter. In other cases there is an inflammation of the bursa serosa in the neighborhood of the joint. In the case forming the text of his lecture the bursa serosa of the psoas was the part involved. Finally, neoplasms of the pelvis or of the upper extremity of the femur may give rise to symptoms simulating coxalgia, as in a case cited by the speaker in which an hydatid cyst of the femur was mistaken for coxalgia. Various periarticular affections produce reflex contractions, especially of the pelvi-trochanteric muscles, which cause the patient to assume vicious attitudes that may lead one to suspect the existence of coxalgia. It is only by attention to the minutest details of each case that an error in diagnosis can be avoided. When there is any doubt, the patient should be anæsthetized and, muscular resolution being obtained, if the articulation is healthy it can be moved in every direction without causing the least friction.

In regard to the second class of cases, Brodie, in 1837, was the first to call attention to these under the name of spasmodic coxalgia and articular neuralgia,—terms which have been generally replaced by that of hysterical coxalgia. Verneuil and Charcot have made a very complete study of this singular form of pseudocoxalgia, which is usually met with in women, though some cases in men have been recorded. It may be observed at any age, though principally in youth, and often at the period of puberty. It comes on suddenly, from some insignificant cause, in persons whose antecedent showed some nervous disorder or who themselves present marked evidences of confirmed hysteria. In certain instances the onset coincides with some slight injury or some great effort. The principal symptoms are pain, muscular contractures, and the resulting vicious attitudes. Cutaneous hyperæsthesia may also be present, causing true nervous attacks whenever the skin is touched. Pain on pressure also shows special characteristics. In coxotuberculosis it is deep rather than superficial, while the reverse is the case in hysterical coxalgia; for, as Brodie remarked, much more pain is caused by pinching the skin than by exercising deep pressure. Another peculiar feature is the resistance of the contractures. In coxotuberculosis, especially in the beginning, these can be overcome to a certain extent by patient effort, and slight movements of the joint can be effected, but in the hysterical form this is never possible. If, in spite of these distinctive signs, the diagnosis remain doubtful, the integrity of the articulation can readily be ascertained under narcosis.

The prognosis, as a rule, is favorable, hysterical coxalgia being a benign affection, always recovering, and that sometimes suddenly; and it is in this manner that attempts should be made to cure it, all violent measures being avoided.

THE NEW PHOTOGRAPHY.

The news of the great discovery made by PROFESSOR ROENTGEN has caused much interest on every side. As is known, these rays are not luminous, since they cannot be seen, but have the peculiar property of passing through opaque bodies. They make no impression on the human eye, but do act on ordinary photographic plates; so that images can be obtained through several layers of paper, through wood, and even through metals. These rays are produced by means of a Geissler tube, an electrical battery, and a small Ruhmkorff coil. The tubes are 30 or 40 centimetres long and have at each end a tiny platinum wire passing a few centimetres into the inside. When the battery is connected with the coil and with the two ends of the tube a very pretty luminous effect is produced, varying with the composition of the glass. In the Geissler tube the air is only rarefied; but in a Crookes tube a vacuum is made as nearly complete as possible, and then, under similar conditions, instead of the effects of the light mentioned above we get a yellowish-green fluorescent tinge limited to the portion of the tube in the neighborhood of the negative, or cathodic, electrode.

The rays of this pole are very curious. Hertz, a German physicist, showed years ago that they could pass through several layers of metal absolutely impermeable to light; and, later on, Lenard, an Hungarian physicist, succeeded in making an impression with them on a photographic plate inclosed in a metallic box of trifling thickness.

At first sight it would seem that M. Roentgen has only re-edited with variations the experiments of his predecessors, but a little attention shows that the rays which bear his name are distinguished by physical peculiarities from the above-mentioned rays: thus Roentgen's rays are not deviated by a magnet, whereas the others are. They seem to be of a special nature and to originate in the action of the cathodic rays on the glass of the tube in which the electric discharge takes place.

The interest of Roentgen's discovery is that it was connected with a most striking experiment, as he was able to photograph the hands of a living person. By placing the hand between a Crookes tube, from which the rays emanated, and the photographic plate, carefully wrapped in black paper, for a quarter of an hour, the usual method of developing the plate revealed most distinctly on its surface the outline of the bones of the hand and even of a ring on the fourth finger. In the same way photographs were obtained of a compass and of a watch inclosed in a wooden box.

On the other hand, Jastrowitz presented to the Medical Society of Berlin a photograph of a child's finger of which a portion had been cut off by an axe, and one of a workman's hand wounded several years ago by some broken glass. The man was convinced that a piece of glass had always remained in his middle finger, although the most careful palpation failed to reveal its presence. Roentgen's rays, however, showed that there was a splinter of glass driven into the bone of the finger. The same rays recently revealed to Mr. Williamson the presence of a knife-blade driven between the last dorsal and first lumbar vertebræ of a sailor who had been picked up dead-drunk on the street and been brought to the hospital with paralysis of the four limbs. Extraction of this foreign body produced immediately a noticeable improvement in the patient's condition. In Vienna Mosetig-Moorhof succeeded in photographing a bullet imbedded in the flesh of the arm. In Berne a child had driven a needle into its hand and Kocher was able to ascertain its exact position by a photograph by the Roentgen rays. In Paris Lannelongue showed the members of the Académie des Sciences photographs obtained by Barthélemy and Oudin representing a femur with lesions of osteomyelitis and a hand with a tubercular finger.

The latter physicians use in their work a Crookes tube, through which they send the discharge from a Ruhmkorff coil capable of giving sparks 6 or 8 centimetres in length. The ordinary sensitive plate, covered with several layers of black paper so as not to be directly affected by the fluorescence of the glass tube or by any other light, is placed at a distance of 10 centimetres from the tube perpendicular to the direction of the cathodic rays, when the object of which a photograph is desired has been placed between the tube and the plate. The sitting should last from ten to twenty minutes and the plate should then be treated in the usual manner.

The most remarkable development of Roentgen's discovery is the announcement from Rome that Professor Salvioni, of Perugia, has just discovered a means by which these radiations may be made to so far assist the eye as to enable it to see through all objects which the rays can penetrate; so that the contents of a closed space are revealed. This discovery, if true, will far outstrip the former one in connection with its importance as an aid in diagnosis.

Recent Suggestions in Therapeutics.

Adhesol.—*Adhesol* is the name given by Dufan to a limpid fluid, amber in color and of an agreeable odor, which is neither toxic nor caustic. Applied to the surface of the skin it evaporates in a few minutes, leaving a transparent elastic covering, and when applied to the mucous membranes a very adherent layer. The substance is prepared as follows: 350 grammes (11 ounces) of *copal resin*, 30 grammes (1 ounce) of *benzoin*, and 30 grammes (1 ounce) of *balsam of Peru* are left to macerate for two days in a mixture of 100 grammes (3¼ ounces) of *ether* and 20 grammes (5 drachms) of *essence of thyme*. It is then filtered and 3 grammes (¾ drachm) of *naphthol* added. This new adhesive is, according to Dufan, destined to render great service in surgery and dermatology. (*Rev. de Thér. et de Pharm.*, November 15, 1895.)

Aluminium.—Koppel gives details of three new preparations of aluminium, viz., *boral*, *cutol*, and *soluble cutol*. The first is a combination of *aluminium*, *boric acid*, and *tartaric acid*, and forms white crystals, soluble in water. *Cutol* is a combination of *aluminium*, *boric acid*, and *tannic*

Aluminium (*continued*).

acid, and is a brownish, insoluble powder. It combines with *tartaric acid* to form *soluble cutol*. The indications for the use of *boral* are limited. *Cutol* may be prescribed for ointment, and is of great service in the treatment of weeping eczema and pruriginous affections, in the following formula: ℞ *Cutol*, 4 grammes; *olive-oil*, 10 grammes (2½ drachms); *lanolin*, q. s. to make 40 grammes (1¼ ounces). When the secretion has disappeared the following powder may be used: *Cutol*, *oxide of zinc*, and *talc*, each 10 grammes (2½ drachms). *Soluble cutol* gives good results in the treatment of burns of the second degree, and a solution of *soluble cutol* and *glycerin*, 1 to 10, applied locally, causes rapid retrogression of follicular angina. The same solution may be employed in catarrhal metritis. For hæmorrhoids, an ointment containing 10 per cent. of *cutol* may be given, while fissures of the hands may be treated by applications of *cutol*, 3 grammes (46 grains); *oil of sweet almonds* and *lanolin*, each 15 grammes (3¾ grains); *orange-flower water*, 10 grammes (2½ drachms). (*Thér. Monat.*, November, 1895.)

Burns.—Rouanet, of Toulouse, praises *lanolin* in superficial burns. The surface of the burn is first washed in 3-per-cent. *boric-acid solution*, the blebs being previously opened. A thin layer of *lanolin* is placed over it and then a layer of gutta-percha which has been dipped in Van Swieten's solution and drained, and the whole wrapped in cotton and fastened with a tarlatan bandage. This dressing is to be renewed daily. The *lanolin* absorbs all the serum secreted by the burned surface, while it has the advantage of not crystallizing on the surface, but remaining oily. It also causes the rapid disappearance of pain. (*Arch. Méd. de Toulouse*, January, 1896.)

Gastro-enteritis of Infants.—*Infusion of calumba*, 1.75 grammes (27 minims); *bismuth subnitrate*, 3.00 grammes (46 grains); *orange-flower syrup*, 15.00 grammes (3¾ fluidrachms). Teaspoonful every two hours. Vomiting generally ceases after one or two doses; diarrhœa disappears in from twelve to twenty-four hours. (E. Trabandt, *Thér. Monat.*, p. 637, 1895.)

Guaiacol in Tuberculous Cystitis.—Dr. Gabriel Colin finds that an oily solution of *guaiacol* 1 to 20 or of *carbonate of guaiacol* 1 to 100 acts as a powerful anæsthetic of the bladder and also as an antiseptic, the latter property being increased by the addition of 1 gramme of *iodoform* to the solution. It seems to him, therefore, that intra-vesical injections of *guaiacol solution* may be used to advantage in the treatment of painful cystitis, the addition of *iodoform* being especially indicated in cases of purulent cystitis of microbic origin, as tuberculous cystitis, in which pain is the predominating symptom. He gives details of four cases in which such treatment gave him satisfactory results. (*Jour. de Méd. et de Chir. Prat.*, January 25, 1895.)

Hæmorrhage After Tooth Extraction.—Dr. A. E. Hind succeeded in arresting a rebellious hæmorrhage after tooth extraction by freezing with an ethyl-chloride spray. To prevent recurrence after thawing he plugged the socket with wool soaked in *tincture of hamamelis.* Not another drop of blood escaped and there was no pain. (*Lancet*, January 25, 1896.)

Intra-peritoneal Rupture of Bladder.—DR. C. K. BRIDDON, of New York, considers the following as the proper course to pursue in such cases: Open the peritoneum; close the rent in the bladder securely by closely-applied silk sutures; irrigate the abdominal cavity with hot sterilized water; close only the upper portion of incision in its walls, filling the lower end with a tamponade of gauze passed to the bottom of the pelvis; drain the bladder by means of a large flexible catheter passed through a perineal incision, and maintained there by any device that fulfills the indication. (*Annals of Surgery*, December, 1895.)

Nasal Wash.—J. E. RHODES, of Chicago, recommends the following antiseptic tablet as a nasal wash, one of them being dissolved in from one-half to two-thirds of a glass of luke-warm water: *Potassium chlorate*, 2½ grains (0.16 gramme); *sodium bicarbonate*, 10 grains (0.65 gramme); *sodium chloride* (C. P.), 10 grains (0.65 gramme); *sodium salicylate*, 5 grains (0.32 gramme); *sodium biborate*, 5 grains (0.32 gramme); *thymol*, $\frac{1}{8}$ grain (0.008 gramme); *eucalyptol*, $\frac{1}{4}$ minim (0.015 gramme). (*Jour. Am. Med. Assoc.*, January 18, 1896.)

Nitroglycerin in Gall-Stone Colic.—DR. G. LINDSAY TURNBULL, of London, gave *tabellæ* of *nitroglycerin*, $\frac{1}{100}$ grain (0.00065 gramme) each, in a case of gall-stone colic, with excellent results. The patient took one dose of the medicine when the pain came on, and was relieved in a few minutes. The author suggests its use in cases in which morphine is badly tolerated. (*Lancet*, February 8, 1896.)

Seasickness in Short Voyages.—No food or liquids should be taken if the voyage last only a few hours; if longer, only the smallest possible quantity of either. The night before embarkation a liver-acting aperient, such as *calomel* (3 grains—0.2 gramme) or blue pill should be taken, followed in the morning by a saline purgative, such as *citrate of magnesium.* When on board the steamer, if the passage be by the night service, a full dose of the solution of *chloralamid* and *bromide of potassium*, known as *chlorobrom* (2 tablespoonfuls) should be taken, and the passenger should at once retire to his cabin to rest and sleep. If, by the day service, a minimum dose (teaspoonful) should be taken and the passenger should remain on deck. Only under exceptional circumstances is a second dose necessary. (M. CHARTERIS, Glasgow, *Practitioner*, February, 1896.)

Thyroid Medication.—PROFESSOR LÉPINE, of Lyons, gives the following indications for the use of the thyroid-gland treatment: (1) operative and spontaneous myxœdema; (2) certain cases of obesity; (3) in non-cystic goitres and some cases of mental alienation, though here the results are incomplete; (4) in special cases of exophthalmic goitre, in which it occasionally gives good results, though here the greatest prudence is necessary; (5) in certain chronic affections of the skin, particularly psoriasis.

Thyroid Medication (*continued*).

Professor Lépine prefers the use of the fresh gland, pounded fine and given in wafers. In certain cases the extract can be injected, not under the skin, but into the rectum. (*Semaine Méd.*, February 12, 1896)

New Books Received.

The editor acknowledges, with thanks, the receipt of the following books :—

THE FUNCTIONAL EXAMINATION OF THE EYE. By *John Herbert Claiborne, Jr., M.D.* Philadelphia : The Edwards and Docker Company, 1895.

SYPHILIS IN THE MIDDLE AGES AND IN MODERN TIMES. By *Dr. F. Buret*, Paris. Translated from the French, with Notes, by *Dr. A. H. Ohmann-Dumesnil.* Philadelphia : The F. A. Davis Company, 1895.

COLOR VISION AND COLOR-BLINDNESS A Practical Manual for Railroad Surgeons. By *J. Ellis Jennings, M.D.* Philadelphia : The F. A. Davis Company, 1895.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs :—

Second Annual Report on Births, Marriages, Divorces, and Deaths in the State of Maine for 1893. Published by the State, 1895.——Annual Report of the Board of Managers of the Maryland Hospital for the Insane, Baltimore, 1895.——Eleventh Annual Report of the New York Post-Graduate Hospital for 1895.——Degenerative Heredity, by **Charles Denison**, Denver, Col., 1895.——A Case of Subchordal Spindle Celled Sarcoma, by **H. S. Birkett**, Montreal, 1895.——Urethroscopy in Chronic Urethritis, by **F. C. Valentine**, New York, 1895.——A New Method for the Detection and Estimation of Sugar in the Urine.——Traumatic Separation of the Lower Epiphysis of the Femur, by **A. H. Meisenbach**, St. Louis, 1895.——The Technics of Maunsell's Method of Intestinal Anastomosis, by **F. H. Wiggin**, 1895.——Practical Urethroscopy, by **H. R. Wossidlo**, Berlin, Germany, 1895.——Tumor and Large Cyst of the Cerebellum, with Symptoms Extending over Several Years, by **J. T. Eskridge**, Denver, Col., 1895.——The Importance of Careful Examination of the Urine before Surgical Operations, by **A. R. Elliot**, Chicago, 1895.——Du Bouton Endemique, observé a Bahia, Bresil, par **M. Juliano**, 1895.——Hyperthermy in a Man, by **A. Jacobi**, New York, 1895.——Die plastischen Operation an Scheide und Damm in den Vereinigten Staaten, von **F. T. B. Fest**, 1895.——Extraction d'une esquille osseuse placée dans le tissue cellulaire périœsophagien, **M. Depage**, Bruxelles, 1896.——Craniectomy An Improved Technique, by **A. H. Meisenbach**, Chicago, Ill., 1895.——Septic Peritonitis, by **Louis Frank**, Louisville, 1895.——The Fate of Micro-organisms in Inspired Air, by **St. Clair Thomson**, and **R. T. Hewlett**, London, 1896.——Treatment of Uterine Retrodisplacements by Vaginal Fixation, by **F. H. Wiggin**, New York, 1895.——The Necessity of Complete Extirpation of Tumors and the Importance of Rapid Cicatrization of the Wound, by **F. H. Wiggin**, New York, 1895.——The Johns Hopkins Hospital Reports, vol. v., Baltimore, 1895.——Infantile Intussusception, by **F. H. Wiggin**, New York, 1896.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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OF THE

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

28 RUE DE MADRID, PARIS, FRANCE.

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(End of Editorial Department of Journal for March, 1896.)

FERRATIN: IRON TONIC AND FOOD.

In Sajous's "Annual of the Universal Medical Sciences," 1895, vol. v, A–90, 91, Dr. Dujardin-Beaumetz summarized the record of Ferratin, the new iron food and tonic reconstructive, as follows: "Ferratin is the name given by Schmiedeberg,[*][†] of Strasburg, to that combination of iron which is found in the normal tissues and which is stored up in the latter as a reserve from which it may be drawn for the formation of blood. He has succeeded in producing this substance, by artificial means, in the form of a fine powder of red-brown color, like oxide of iron. Two forms are known to commerce,—the one simple and insoluble in water, the other a sodium compound which readily dissolves on stirring after being allowed to stand a little while in water. The latter must be as free as possible from lime, otherwise an insoluble calcium compound is formed. Ferratin, in contradistinction to those compounds of iron hitherto in use, is readily assimilated, and does not produce any unpleasant disturbances in either the gastric or enteric functions, even when used for a lengthy period; indeed, in some cases its exhibition seems to produce improvement in the appetite and regularity in defecation. As a portion of the substance is decomposed by the acid gastric juice and also by sulphuretted hydrogen, a sufficient quantity of Ferratin must be ingested to leave an overplus in the bowel-tract so that the organism may pick up as much as it requires. There is no necessity whatever to anticipate overloading of the organism with the iron, as absorption and excretion appear to be mutually controlling. Excretion does not take place through the kidneys. The daily dose for adults is 1 to 1.5 grammes (15½ to 23¼ grains). Acids should be avoided, but no other restrictions are necessary. Schmiedeberg points out that Ferratin is first and foremost a food, and its use is indicated in all cases in which nutrition and blood-formation are unsatisfactory.

"Banholzer, of Eichhorst's clinic,[‡][§] relates his clinical investigations with this preparation. In anæmia following acute disease the hæmoglobin was quickly increased (over 5 per cent. in eight days), as also the number of red cells. In chlorosis the same results were visible even in a more marked degree. The general condition was improved and the increase in weight in most cases considerable. The good effects on the appetite were obvious. When compared with Blaud's pills, which also give good results, Ferratin was found to lead to a greater increase in the hæmoglobin. John Harold[||] found that in three cases of severe anæmia the preparation appeared to exert a remarkable hæmatinic effect; it did not interfere with digestion or produce any constitutional disturbance. In one of the patients, iron, in the form of a scale-preparation or as reduced iron, had been given previously for the twelve months without apparent benefit.

"Germain Sée[¶] has also tested Ferratin, and finds that it can be employed in men apparently healthy or in children and chlorotic subjects, the curative action not being interfered with by injurious secondary effects, as is often the case when ordinary ferruginous preparations are used. The dose used by him is from 0.05 to 1.5 grammes (⅞ to 23¼ grains) two or three times a day. Each dose contains about 7 per cent. of iron. Marfori[**] states that care should be taken not to associate it too closely with acid materials. Hugo Wiener[††] reports twenty cases in which it produced favorable results."

[*] Archiv für experimentelle Pathologie und Pharmacie, Leipzig, B. xxiii, Nos 2 and 3.
[†] Provincial Medical Journal, Leicester, Eng., April 2, 1894.
[‡] Centralblatt für klinische Medicin, Leipzig, January 27, 1894.
[§] British Medical Journal, February 17, 1894
[||] Practitioner, London, August, 1894.
[¶] La Presse Médicale, Paris, August 25, 1894.
[**] Annali de chimica e di farmacologia, Milan, February 1, 1894.
[††] Prager medicinische Wochenschrift, Prague, April 18, 1894

TREATMENT OF WOUNDS.

Dr. Louis Cohn, in the treatment of small wounds, disinfects thoroughly with sublimate solution 1 to 2000, and then paints on a 10 per-cent. solution of Aristol in collodion. This closes the wound hermetically and prevents access of septic substances.—*Der Hausdoktor*, June, 1895.

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Selections from Society Proceedings.

FRANCE.

SOCIÉTÉ MÉDICALE DES HÔPITAUX.

Creasote in Tuberculosis.—M. BURLUREAUX, in advocating the use of creasote in large doses in the treatment of pulmonary tuberculosis, insisted upon two facts: (1) that the untoward symptoms caused by it, though apparently serious, are never mortal, and disappear within six or eight days without leaving any trace; (2) that such symptoms occur but rarely, since he had only observed them in three cases, though he had been using large doses for the past five years. Hence there is no more reason for abandoning the drug on account of the accidents that it may cause than there is for abandoning any other active medicament. In his opinion, not to give the largest dose that can be tolerated in each individual case is to deprive the patient of the benefits of the treatment. The physician must decide the limits of the dose, guided by the various manifestations of intolerance.

M. FAISANS asserted that creasote had by no means the virtues of a specific, and that it was contra-indicated in all cases in which there was fever, habitual dyspepsia, or cardiac erethism. It was true that large doses produced considerable improvement, especially in the body-weight; but the same result could be obtained by codliver-oil in large doses (200 to 300 grammes—6½ to 9½ ounces—daily) with 250 grammes (8 ounces) of meat-powder, according to M. Debove's method. In short, while creasote is one of the best balsamics and of great service in bronchorrhœa, it can in no way be admitted as a specific.

The views of M. Faisans were coincided with by MM. FERRAND and LEREBOULLET.

M. CATRIN expressed the opinion that creasote injections were seldom indicated, but often contra-indicated. If a tuberculous patient has any tendency to erythism, creasote should be avoided. It may be of service in the beginning of the disease in what may be called the latent stage. While of value in bronchial catarrh, it could not, to his mind, be looked upon as a specific.

M. Fernet stated that hygienic factors alone could bring about a cure of tuberculosis of slow evolution. Among these factors was to be cited over-feeding,—especially praised by M. Debove,—the administration of alcohol, codliver-oil in large doses, and the use of hydrotherapy. He also regarded creasote as contra-indicated in the so-called erethic form of phthisis in alcoholic or gouty patients or those with arterio-sclerosis.

M. Hanot had noted the disappearance of urobilin from the urine in twenty-eight patients treated by rectal injections of creasote, and he asked whether favorable effects of the administration of the drug by the rectum did not depend on the fact that its antiputrid action was exerted more directly.

M. Hayem believed that creasote was always injurious to the digestive tract, especially in tuberculosis, as it is one of the most irritating of drugs and one of the factors in medicamentous gastritis. As regarded its action on urobilin, M. Hayem has observed that in many patients showing a large quantity of the latter in the urine on entrance to hospital it completely disappeared after some weeks of repose, diet, and forced abstinence from alcoholic drinks.

Société Français de Dermatologie et Syphiligraphie.

Treatment of Syphilis by Injections of Gray Oil.—M. le Pileur stated that since 1891 up to the present time he had treated 600 cases of syphilis by intra-muscular injections of gray oil, giving in all 3500 injections. The pain following the injections varies not only according to the individual, but also from one injection to the other. Among the accidents noted by him were an abscess, an eschar following a superficial injection, ecchymosis, and in two cases swelling about the injection. Most of these accidents were due to the varicose condition of the limbs. Stomatitis occurred in 21 cases, 13 of them being light cases of gingivitis in patienns who had undergone previous mercurial treatment.

The advantages of the method, according to M. le Pileur, are: (1) absolute certainty; (2) greater intensity of action, since an injection of 3½ drops weekly corresponds to at least 3 pills of sublimate daily; (3) rapid disappearance of symptoms rebellious to all other treatment.

M. Barthélemy expressed himself as a partisan of the method, the pain being slight, and sometimes only occurring after the third or fourth injection. The principal inconvenience was that errors in dose were possible, which inconvenience was not met with when calomel was used.

M. le Pileur agreed that it was difficult to inject exactly the 3½ drops of gray oil representing the usual dose; still he believed it was possible to arrive at exact dosage. The real cause of pain following the injections was, in his opinion, the use of olive-oil as an excipient. When vaselin was used, the pain was much less.

M. **Hallopeau** regarded the method as a dangerous one. A patient treated by a Paris physician, and afterward admitted to hospital in the wards of M. Hallopeau, bore three injections of 5 drops without showing any untoward symptoms, but a fourth injection of 10 drops was followed by a fatal diarrhœa.

M. **de Beurmann** had employed some 200 injections at the Lourcine Hospital, and had noted the occurrence of stomatitis more frequently in these cases than when he gave 2 Dupuytren pills daily,—a large dose. A proof that the injections are badly borne is that the patients leave the hospital. However, in severe cases, the speaker made use of injections of the soluble salts of mercury, which were most efficacious, and were not followed by such intense stomatitis as were the insoluble preparations.

M. **Gastou**, in referring to the statement of M. le Pileur, that the injections were contra-indicated in cachectic or varicose conditions and in albuminuria, stated that mercurial injections might cause the disappearance of albuminuria, as was proven by certain cases observed by M. Cathelineau and himself in the service of Professor Fournier.

M. **Jacquet** thought that the cases in question must have been cases of nephritis of syphilitic origin.

M. **de Beurmann**, believed that the presence of nephritis formed a double indication for the employment of calomel, which acted not only as a specific, but also as a diuretic.

M. **Barthélemy** would not use mercury in all cases of albuminuria in syphilis, but would avoid its employment in instances of interstitial nephritis.

M. G. **Thibierge** called attention to the fact that the great opposition manifested against the method in August, 1894, when this same question was discussed by the society, had become singularly modified, so that papers in its favor read at recent meetings had met with no important arguments against it. An acquired fact at the present time seems to be that the injection of soluble salts must give way to the injection of gray oil or massive doses. Since the fabulous doses at first employed have been abandoned, serious intoxication is no longer to be feared; while aseptic precautions and the choice of the preparation used prevents the abscesses at first so frequent. Insoluble injections are made at rather long intervals, in this being preferable to the soluble ones, which must be made more frequently. Of the former, in most cases gray oil meets all the requirements, and it is only when the lesions involve important regions or organs, or when the diagnosis requires confirmation, that recourse must be had to injections of calomel; even then the gray oil may be resumed after a time.

The insoluble injections are formally indicated in all grave cases in which life is endangered or in which other methods have proved of no avail. They are of value to replace frictions in patients who cannot take mercury by the mouth; while their innocuous nature permits of their use in cases of ordinary syphilis if the gums and teeth are in good condition. The method should therefore no longer be regarded as an exceptional one, exclusively applicable to grave cases, but it should rather be considered as one of the best methods of mercurialization, or even the best, from the stand-point of certainty, rapidity, and intensity of action.

M. Mauriac expressed himself as opposed to the method, believing that the more ordinary measures suffice in 99 out of 100 cases.

M. Fournier stated that, as in all other diseases, a method which succeeds in one case may fail in another; hence the necessity of ascertaining the needs of each individual case. He described the case of a man who had suffered from pains in the head and exostoses of the skull, for which 100 injections had been given without effect. Ordinary treatment was also unsuccessful. M. Thibierge then tried injections of gray oil, and the pains and exostoses rapidly disappeared. This result appeared to be permanent, but twenty months later the exostoses re-appeared, showing that one can never count on the permanence of the recovery.—*La Semaine Médicale*, February 5, 1896.

GERMANY.

Berlin Medical Society.

Thyroid Extract in Goitre.—Herr Stabel gave the results of his experiments in Professor von Bergmann's clinic in 26 cases of goitre, treated by thyroid medication. These results agree with those reported from other countries, and are entirely favorable. The best effects were obtained by the use of the fresh gland, and Stabel believes that the tablets are not to be recommended, as he noted bad effects from their use in several instances. He reports the case of one man, 50 years old and quite obese, who took a large quantity of the tablets, and who died several days after severe mental symptoms. Post-mortem examination showed acute œdema of the brain, probably following thyroidin poisoning. In two other cases mental alienation followed the use of the tablets.

Ewald stated that he had obtained better results with the tablets than with the fresh gland, observing the most remarkable effects in young chlorotic girls suffering from parenchymatous goitre. Complete recovery, however, did not take place. He had noted but slight symptoms of thyroidism, as moderate albuminuria with casts, disappearing as soon as the treatment was suppressed.

Mendel had obtained no improvement in ten cases in which he had tried the tablets. He was obliged to abandon the treatment on account of the palpitation and emaciation which it caused. He did not regard it as suitable for cases of Basedow's disease, in which there is a tendency toward emaciation.

Senator also stated that he had not met with success by the method, which could only be expected to aggravate the symptoms of Basedow's disease, if the latter depend on an exaggerated function of the thyroid gland.

HAMBURG MEDICAL SOCIETY.

Lesions of the Spinal Cord in Pernicious Anæmia.—HERR NONNE, in a paper on this subject, added 2 new cases of his own to the 19 cases of pernicious anæmia already recorded in which the nervous system was examined. Of these 21 cases the spinal cord was found to be affected in 13. Of Nonne's 2 cases, the first was a woman, 65 years of age, without hereditary syphilitic antecedents, and who had become affected with Bright's disease eight years previously. The anæmia which led to her death had lasted four months. The number of red corpuscles had fallen to 1,000,000, and the quantity of hæmoglobin was 15 per cent. There were no lesions of the ocular apparatus, and no somatic disturbances of the nervous system. The post-mortem examination showed extreme anæmia and fatty degeneration of the heart, but no other organic lesions. Histological examination showed marked proliferation of the inner coat of the crural artery, and three small foci of acute myelitis in the cervical region of the spinal cord,—two outside the lateral cornu, and unsymmetrical, the other near the anterior commissure. These foci involved the myelin and axis-cylinder. The other regions of the cord, including the gray substance, were intact. The anterior and posterior spinal arteries also appeared not to be affected, but there were vessels in the cord with thickened walls showing hyaline degeneration, and the lymph-spaces were dilated. The case is interesting, as showing that the medullary lesions of anæmia may present themselves in the form of small areas of acute myelitis.

The second case was that of a woman of 68 years, who, after family troubles, developed general weakness, with severe anorexia and anæmia. The number of red corpuscles was less than 1,000,000, and the hæmoglobin 10 per cent. Here, also, no objective disturbances of the nervous system could be noted. At the necropsy two foci of medium size were found in the right posterior column and a smaller one in the left posterior column. These lesions were in the cervical region and situated around a vessel. The anterior and posterior gray substance was intact and the spinal arteries also were normal. Both cases thus refute the theory of Rothmann, that the medullary lesions of anæmia consist of a more or less characteristic combined sclerosis, depending on a primary alteration of the gray substance.

Nonne expressed the belief that any case of anæmia of a more or less progressive type might cause changes in the spinal cord, and he questions whether the same may not be true of chlorosis, though no such case has come to autopsy.

GREAT BRITAIN.

BRITISH GYNÆCOLOGICAL SOCIETY.

Uterine Cancer Treated by Chloride of Zinc.—MR. F. BOWREMAN JESSETT showed a specimen from a case of advanced uterine cancer treated by chloride-of-zinc paste. The patient was greatly relieved, her life was prolonged, and she had the hope that the disease was cured. She was 74 years of age, highly nervous, and suffered from heart disease, and it has therefore been thought that she could not bear the shock of vaginal hysterectomy. After scraping away as much of the disease as possible with a Volkmann spoon Mr. Jessett applied the dredger, and then packed with chloride-of-zinc wool. The slough came away on the tenth day. The specimen illustrated how difficult it was in some cases to avoid the accident of a slough into the rectum. In this case a fæcal fistula occurred; but ten weeks after the operation, however, this had quite healed. The specimen supplied an answer to the question whether the peritoneal covering of the uterus shared in the process of sloughing. In this case the peritoneal reflections, both in front and behind, could be plainly seen on the specimen.

Dr. Purcell was in doubt as to the presence of the peritoneum on the slough shown, and said that the principal accident to be feared was sloughing into the rectum, but this risk could be minimized by applying sufficient bicarbonate of soda to neutralize the effect of chloride of zinc.

Dr. Heywood Smith stated that the technique of the caustic operation was most important. He would ask whether in this case the chloride-of-zinc wool was used too wet; it should be only damp, as advised originally by Sims. He thought the bicarbonate of soda should be applied next to the chloride of zinc, without the intervention of gutta-percha

Mr. Jessett replied that in this, as in other cases, he used a gutta-percha cap, but inside it, next to the chloride-of-zinc wool, he inserted some dry wool, which absorbed excess of chloride of zinc sufficiently to act on the lower part of the uterus. As an additional precaution he had lately adopted the further procedure of packing the vaginal walls round with lint covered with iodoform ointment. He had found that if the wool were too dry it had little or no effect. He used the paste in pellets, which he packed in one at a time into the uterine cavity, and by this means the caustic was applied as dry as was consistent with efficacy.—*Medical Press and Circular*, February 26, 1896.

Laryngological Society of London.

Laryngeal Complications of Typhoid Fever.—A discussion on this subject was opened by Drs. Kanthack and J. A. Drysdale. Dr. Kanthack, who read the paper, said the general situations of the ulcers were the tip and edges of the epiglottis and the neighborhood of the vocal processes. The assumption that the ulcers were decubital was set aside as erroneous. That they were produced by repeated injuries acting on debilitated tissue was more probable. That they were typhogenetic on the ground that the ulcerations affected the adenoid tissue of the larynx was incorrect, as in the above regions no such tissue existed. The evidence of the assumptions from analogy of other parts, such as periostitis and parotitis, that the typhoid bacillus produced the ulcers, was insufficient. The bacteriological evidence was very incomplete, and such as there was pointed against the specific typhogenetic nature. Clinical evidence, too, did not support this theory, as there seemed to be no relationship between the symptoms of the fever and the laryngeal lesions. The lesions were undoubtedly caused by micro-organisms. There was the strongest evidence that these were pyococci and not, with very rare exceptions, the typhoid bacillus.

Dr. Watson Williams, of Bristol, was of opinion that, while laryngeal lesions were sometimes undoubtedly the result of septic infection, they were in the main specific and due to typhoid toxin for the following reasons: 1. As regards lymphoid tissue Cornil and Ranvier found, in the more acute forms of laryngitis in typhoid, that the lymph-follicles were tumefied, and there were nodules in which the infiltration and the multiplication of nuclei were entirely similar to what was observed in the follicles of the small intestine. 2. The frequency of initial lung symptoms in typhoid suggested a specific origin, and the typhoid bacilli had been found in the lung in numerous instances. Newman found them in the kidney in 11 out of 48 cases, and concluded that they appeared only in the urine when the kidney was directly involved. 3. The frequency and characteristic aspect of laryngeal ulcers in typhoid, as compared with other exanthemata, pneumonia, etc., were strong evidence of their specific nature. The intestines in congenital typhoid did not present ulcerations due to the absence of saprophytic micro-organisms, especially the bacillus coli, which added to the virulence of the typhoid bacillus in after-life; so in the larynx the ulcerative process might be due to its exposure to the combined action of these bacilli. 4. It was hardly possible to account for the inoculation of certain cases except by aërial infection.

Mr. S. G. Shattock exhibited some preparations showing the typical situation of the ulcers. Having especially examined the point, he could say that normally there was no lymphoid tissue over the vocal processes of the arytenoids.

Dr. J. Horne expressed the opinion that ulceration of the larynx in typhoid was not necessarily of a typhoid origin. In some cases the ulceration had been found post-mortem to be of a tuberculous nature. Bearing in mind that tuberculosis more commonly followed typhoid than any other fever, it might be that typhoid rendered the laryngeal tissues more vulnerable to the attacks of the tubercle bacillus.

The president, Dr. Semon, asked why the cricoid cartilage was so frequently the seat of disease. There were several specimens showing this without disease at the processus vocalis.

Dr. Kanthack, in replying to Dr. Watson Williams, did not accept the statements with regard to lymph-follicles in the larynx. His own and other observations showed the absence, even in disease, of adenoid tissue over the processus vocalis and tip of the epiglottis. He desired to know what authority Dr. Watson Williams had for stating that the typhoid bacillus had been found in the lungs in "numerous instances" (Councilman and others). The presence of Eberth's bacillus in the blood during typhoid was generally acknowledged to be extremely rare. Its frequent occurrence in the urine was indisputable, but this was no argument that the tissues were generally infected. To argue from congenital typhoid was, in his opinion, to argue from the unknown. Dr. Williams assumed that the typhoid bacillus in the lungs produced no ulcerative lesions because it did not co-exist with the bacillus coli. Dr. Kanthack, on the other hand, had shown that it was always there; so, following Dr. Williams's own argument, necrotic lesions in the lungs should be common. Most authors had failed to find typhoid bacilli in suppurative and inflammatory complications of typhoid. With regard to the president's question, he was not prepared to answer without a little more thought and study, but he had always considered the cricoid perichondritis to be secondary to the ulceration over the processus vocalis.—*British Medical Journal*, March 7, 1896.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY, LONDON.

Malarial Fever.—An interesting discussion on this subject was introduced by the joint paper of DR. MARSHALL, of Huelva, Spain, and DR. THIN, of London, who endeavored to prove the following proposition: "As malarial fevers assume a variety of types in different parts of the world, and as at least three—some authorities would say five—varieties of parasites have been found associated with as many distinct types of fever, it appears probable that as many varieties of parasites exist as there are varieties of fever, and that there is thus opened out to us a large field for observation in undertaking the study of the parasites found in the blood of malarial patients." The paper of the authors was a contribution to this aspect of the subject, and the number of observations made on the blood was large. Dr. Marshall recorded the clinical histories of his patients at Huelva in Spain, and he and Dr. Thin simultaneously examined the specimens of blood taken from these patients. With the exception of some observers in India, all who have carefully examined the blood of malarial patients are now agreed that there is a living parasite to be seen therein, and that Laveran's discovery was correct. The parasite undergoes various stages in its development, and is seen in different forms and shapes, and the chief interest of the paper centred in the question as to whether the observations made by Dr. Marshall and Dr. Thin confirmed the statments of Golgi, that these differences were characteristic of the different varieties of the fever. The *Lancet*, in commenting on the paper (March 7, 1896), states that, in view of the subsequent discussion, it cannot be said that the authors quite proved the proposition which they had so absolutely laid down. The young spore of the hæmatozoon is first seen in an amœbic form, which attacks a red corpuscle and, as the amœba develops, pigment is observed in its substance; and the writers of the paper consider that the character of these pigment-granules and their mode of arrangement are distinctive of each variety of parasite; but there is considerable question whether such pigmentation is not really accidental and not distinctive. Again, it is a further question whether the alterations in size and color of the red blood-corpuscles, as the parasite is developing, are as characteristic as Dr. Marshall and Dr. Thin believe them to be. In fact, asks the *Lancet*, are they not insisting too much on minute differences which may only be accidental and possibly due to changes in the density of the medium and the effects of reagents? In addition to the amœbic form crescents have also been seen in all varieties of malarial fever, although they are more numerous in the chronic fevers, and especially in those which do not readily give way to quinine. Both of these forms have been observed to flagellate and the flagella to become free and move about most actively in the blood. Such movements are anything but those of a "death agony." The sporulating and roseate forms are seen in tertian and quartan agues, and their different appearances may, as Golgi says, be characteristic of these two typical forms of malarial fever, and Dr. Marshall and Dr. Thin put forward their cases to strengthen his views. For real confirmation, however, simple tertian and quartan cases untreated for some days by quinine should have been selected, whereas those narrated by Dr. Marshall are cases of supposed double tertian and double quartan and other irregular forms of the fever; so that further observations are still needed to prove this point as well as the relationship between the amœbic, the sporulating, and the crescentic varieties of the plasmodium.

The experience of Dr. Marshall is the same as that of other observers, —that malaria is often very narrowly localized, and he has reason to believe that it hugs the soil very closely and is not readily carried by currents of air from one place to another, whilst moist conditions favor its development and render it more fitted to establish itself in the human body. He is, however, very skeptical whether drinking-water is ever the vehicle by which the parasite is introduced; and, although he may be correct in his statement that this is certainly not the medium at Huelva, too little is known of the life-history of the parasite outside the human body to act on this view as universally true. The instances mentioned by Dr. Curnow and the experiences of speakers who had lived long in India are strongly in favor of the hypothesis that water may be the means by which the poison gets into the system, and certainly all suspicious water must still be avoided. The part played by the mosquito was referred to by the authors, who, however, do not appear to attach as much importance thereto as does Laveran and some other recent observers.

During the discussion the prophylactic value of quinine, as apart from its curative effects, was referred to by several speakers, and many important and apparently conclusive instances were brought forward in support of its prophylactic influence. No one should go into a malarious country or district without taking a daily ration of quinine in small doses of from 5 to 10 grains. In cases of working parties or expeditions this practice should be insisted on by the responsible officer in charge, just as a daily ration of lime-juice is made imperative in the mercantile marine, and is daily administered under the supervision of the captain or some other officer in authority. Quinine may be given in many ways, but if put into the coffee which is regularly served out to the men in the morning a very simple, regular, and efficient mode of administration is secured, and the palate soon gets accustomed to the flavor of the drug.

UNITED STATES.

New York Academy of Medicine.

Recent Progress in the Treatment of Affections of the Upper Respiratory Tract.—Dr. F. H. Bosworth opened a discussion on this subject by a paper on the nose and accessory sinuses, stating that among the prominent factors responsible for the progress in this department of medicine during the past fifteen years was the discovery of the local anæsthetic properties of cocaine by Carl Koller. Aside from its anæsthetic action, this agent had contributed much to laryngology and rhinology by its property of squeezing the blood out of vascular tissues, and so facilitating both diagnosis and treatment. In 1885 had appeared what he considered to be the first paper in which was presented the true physiology of the nasal passages. He had contended that the function of the turbinated bodies was to pour out serum, which was taken up again by the inspired air. A proper appreciation of the important function of the nasal passages made it evident that the important indication for treatment was to restore or maintain the normal respiratory function of these passages. He did not think that the nasal septum had any particular function, and consequently if it encroached upon the lumen of the passages it was proper to cut it away freely. It was now known that a purulent discharge indicated an empyema of one of the accessory sinuses. Ethmoid disease he had found to be frequently accompanied by diseases of the antrum. Both diagnosis and treatment were more definite than formerly.

Dr. M. J. Asch said that in the enthusiasm over the value of cocaine it should not be forgotten that the abuse of this drug had often led to the development of a drug habit almost as baneful as the alcohol or morphine habit. Another danger from cocaine arose from this very important property of temporarily depleting the tissues of blood, for operations done under cocaine anæsthesia were sometimes followed by secondary hæmorrhage. Although puncture of the inferior meatus in disease of the maxillary sinus had been recommended as a simple method of treatment, he had found that such was not the case, and that owing sometimes to the peculiar conformation of the sinus a puncture through this meatus entirely failed to reach the sinus.

Dr. R. C. Miles said that he could hardly conceive of nasal surgery being carried on intelligently without the use of cocaine. The nasal septum, in his opinion, was not as useless as Dr. Bosworth seemed to believe; its numerous glands should be enough to refute such a statement. In the treatment of polypoid degeneration of the frontal sinus, he had obtained good results from curetting.

Dr. J. W. Gleitsmann said that he had also met with difficulty in puncturing the antrum of Highmore from the lower meatus with Schmidt's instrument, until Schmidt had called his attention to the fact that the point of puncture should be about three-fourths of an inch posteriorly; since then he had frequently done it with good result.

Dr. Bosworth said that he had never met with a case of cocaine habit that had seemed to him much more serious than the chewing-gum habit. In many of the so-called cases of cocaine habit alcohol or morphine was an important factor.

Dr. J. E. Newcomb read a paper on the pharynx. Speaking of the best general anæsthetic to use for very short operations, there was much evidence to show that the bromide of ethyl was particularly well adapted for this purpose. With this agent the period of excitement is very transient, vomiting is rare, the vapor does not irritate, and there is no tendency to cardiac disturbance or cerebral anæmia. Its disadvantages are that it produces hypersecretion, and if too long inhaled may produce muscular contractions. In the production of local anæsthesia it had been found that the effect of cocaine could be prolonged and intensified by mixing it with antipyrin; indeed, the hypodermatic injection of a 50-per-cent. solution of antipyrin alone had been found sufficient to relieve dysphagia for twelve hours at a time. In the treatment of naso-pharyngeal tumors the hot snare was not now so commonly resorted to. Electrolysis had yielded good results, but statistics on this point were far from accurate. Metallic electrolysis—*i.e.*, the use of a certain metal for the positive electrode, by which this metal was dissolved by the current and deposited deeply in the tissues—promised good results. When this method was employed, it was customary not to use cocaine, as the operator desired to be guided somewhat by the sensations of the patient. Mycosis was a condition often dependent upon a rheumatic or gouty diathesis and demanding the use of antiseptic solutions, or, better still, the application of the electro-cautery.

Enlarged tonsils in persons under 16 years should be removed by some form of guillotine, but in older persons, or where the tonsils were fibrous and liable to bleed, ignipuncture was more appropriate. For adults, if the shape of the tonsil permitted, he favored the use of the hot snare. Where the tonsils were acutely inflamed, one of the best internal remedies, according to his experience, was salol, although at the outset a tonsillar inflammation might frequently be checked by the local application of guaiacol. Where suppuration seemed inevitable, one should not wait for the abscess to point, but should resort to early incision.

Dr. Gleitsmann said that he had found that bromide of ethyl possessed the advantages claimed for it in the paper, but it had seemed to him that its anæsthetic action was rather too transient for most purposes. He could speak from personal experience of the satisfactory action of a 50 per-cent. solution of antipyrin, hypodermatically administered, in certain obscure neuralgic conditions.

Dr. D. Bryson Delavan discussed the larynx and trachea. He said that intubation was growing in favor as a mode of treating chronic stenosis of the larynx. A new method of treating benign neoplasms of the larynx, and one that bade fair to be exceedingly useful, was the frequent spraying with absolute alcohol. Two cases in his own practice had been completely cured by this simple treatment. In the treatment of malignant disease of the larynx three recent operations were worthy of consideration,—viz., (1) thyrotomy, (2) complete laryngectomy, and (3) laryngectomy with removal of involved glands. Dr. J. Solis-Cohen's plan of attaching the divided end of the trachea to the edges of the cervical wound was a good one, for it decidedly diminished the chance of inspiration pneumonia, and in several cases so treated there had been quite good phonation. Tracheotomy should precede thyrotomy by several days, and in dividing the cartilage it is well to interrupt the continuity of the incision and form a sort of angular recess, so as to assist in keeping the cartilaginous margins in coaptation after the operation. One of the best methods yet proposed for the treatment of tubercular laryngitis was that brought forward recently by Dr. W. F. Chappell,—viz., submucous injections of creasote into the diseased tissue.

Dr. Robert Abbe called particular attention to the fact that operations on the larynx for malignant disease should only be undertaken by surgeons of skill and experience. The only hope of accomplishing much in this class of cases lay in a very radical operation,—the removal not only of the neoplasm and the parts evidently infiltrated by it, but also of the neighboring glands. If this were not done it would be found that, owing to the abundant lymphatic supply to the larynx, recurrence would be exceedingly rapid. Feeding after laryngectomy could be accomplished without difficulty by the use of a catheter introduced through the nose. To prevent the passage of blood during the operation into the trachea, he had used a number of small sponges, with strings attached, packed around the common tracheal tube. This had proved much more satisfactory than any of the special devices for this purpose. His experience with laryngeal papillomata had impressed him very strongly with their remarkable tendency to recur after the most thorough excision and cauterization of the parts. He hoped therefore that the new method of treating these benign but very troublesome growths, by spraying with absolute alcohol, would turn out to be all that was claimed for it.—*Medical News*, February 29, 1896.

Philadelphia County Medical Society.

Filaria Sanguinis Hominis in Philadelphia.—Dr. F. P. Henry presented a number of microscopical slides showing the embryos of the *Filaria sanguinis hominis* alive and active. The blood was drawn from the finger of a white woman in the Woman's Hospital, who had developed hæmatochyluria after labor. The patient was a native of South Carolina, and had been living in Philadelphia not quite one year. Dr. Henry believed the worm had been acquired in the South, and that rupture of a lymph-vessel during the strain of labor had led to the chyluria, with discovery of the parasite.

He stated that the Cuban with chyluria, whose case he had previously reported to the society, had died, and that at the autopsy the abdominal lymph-vessels were found to be much distended, but that neither embryo filariæ nor parent worm could be found. Nevertheless, he believes it to have been a case of parasitic chyluria. Drs. Tyson, Wilson, and Cohen narrated cases of chyluria in which the parasite had not been discovered, despite careful search of the blood both during the day and night, and which were, therefore, presumably non-parasitic. Dr. Henry's case was one of the most common variety, *Filaria nocturna*, and the parasite was consequently not to be found in the blood drawn from the surface-vessels during the day. It was stated that this was the first time the living filariæ in the blood had been demonstrated in Philadelphia.—*Phila. Polyclinic*, February 29, 1896.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

DR. HOLGER MYGIND,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG KIRURGI, OPHTHALMOLOGI, LARYNGOLOGI, OTOLOGI, ANATOMI, HISTOLOGI. PHYSIOLOGI, DERMATOLOGI, SYPHILIDOLOGI, SAARSYGDOMME (TETANUS, HYDROPHOBI, ETC.).

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til DR. LEVISON,
(f. d. DR. MYGIND),
Norrevoldgade, 13,
Köbenhavn.

Purulent Sinus-Thrombosis After Chronic Otitis Media.—K. POULSEN, of Copenhagen, relates the following case: A boy, aged 15, had from his earliest childhood suffered from otorrhœa of the left ear. In January, 1895, pains in the left ear appeared, and on the 15th of February resection of the left mastoid process was performed; the temperature did not, however, fall, and rigors appeared; two days later swelling and tenderness were noted along the left internal jugular vein. The pulse was 120, the sensory system was not involved, and the background of the eye was normal. On the 19th of February the temperature was 37.5° C. (99.5° F.) in the morning and 40.5° C. (104.8° F.) at noon, and the general condition worse. The left transverse sinus was then opened and found to be surrounded by pus, blood appearing after incision of the abscess. The vein was opened, a large puriform thrombus removed, and the wound dressed without ligature of the internal jugular vein. Until the 9th of March the patient had constant high fever, alternating with normal temperature, and several minor metastases appeared, due to retention of pus in the wound by the firm pressure of the iodoform gauze, necessitated on account of recurring bleeding as soon as it was removed or was left loose in the wound. The patient, however, ultimately recovered thoroughly, the external wound healing perfectly, while the discharge from the ear still continued in July, when the case was published.—*Hospitals-Tidende*, No. 38, 1895.

Papillomatosis Universalis.—In the post-mortem examination of a man, aged 79 years, C. RASCH, of Copenhagen, found a great number of cutaneous papillomata spread over the surface of the body and papillomatous tumors on the mucous membrane of the rectum and the sigmoid flexure. The patient had died from the effects of an operation performed on the bladder for the removal of papillomata, the microscopical structure of which was identical with that of papillomatous tumors found after death. —*Hospitals-Tidende*, No. 44, 1895.

Castration for Hypertrophy of the Prostate.—In a man, aged 85 years, who for fifteen years had suffered from increasing dysuria, ROVSING, of Copenhagen, performed extirpation of both testes on account of a very considerable swelling of the prostate, which organ was felt in the rectum as being of the size of an orange. A fortnight later rectal exploration revealed a distinct decrease of the prostatic tumor, and the passing of a catheter, which had been difficult before the operation, was easy. A month later the prostate was nearly half its former size, and the patient began to pass his urine spontaneously. The function of the bladder improved later on very considerably, and was, three months after the operation, almost normal. —*Hospitals-Tidende*, No. 45, 1895.

Aphasia in a Left-Handed Woman.—S. MONRAD, of Copenhagen, describes the case of a woman, aged 63 years, in whom an apoplectic fit had produced paralysis of the left facial nerve, paresis of the left extremities, and homonymous left-sided hemianopsia. She was unable to speak and to write a number of words, and often used the wrong words for many things. Complete recovery took place in eight weeks. The history of the patient revealed the fact that she began to be left-handed when 9 years of age, being obliged to wear the right arm in a bandage for about ten months and since that time she has principally used the left hand.—*Hospitals-Tidende*, No. 29, 1895.

Narcosis Statistics.—During the meeting of the Scandinavian Surgical Society in July, 1895, the following statistics for Scandinavia from February, 1894, to May, 1895, were published:—

	Cases.	Asphyxia and Syncope.	Deaths.
Chloroform	11,047	1.39 per cent.	5 (*i.e.*, 1 : 2256).
Ether	1,279	0.80 "	0
Chloroform-ether	2,122	1.37 "	0
Bromide of ethyl	367	0. "	0
Total	14,815		

EFFECTS OF THE NARCOSIS.

	Vomiting.	Icterus.	Somnolence	Albuminuria.	Diseases of Lungs.	Diseases of Heart and Collapse.	Deaths.
	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.
Chloroform	23.0	0.08	0.37	0.88	0.19	0.29	0.10
Ether	23.9	...	0.08	1.56	0.62	0.15	0.15
Chloroform-ether	21.4	0.04	0.40	0.40	0.32	0.37	0.18

—*Hospitals-Tidende*, No. 29, 1895.

Abdominal Actinomycosis Cured by Iodide of Potassium.—J. SCHON, of Copenhagen, reports the following interesting case: A woman, 50 years of age, had for a couple of months noticed an increasing swelling in the right iliac fossa, where there was a large, hard tumor without any tenderness, reaching upward about two inches beyond the iliac crest and stretching downward under the external part of the Fallopian ligament to the front part of the femur. The tumor was fixed in the depth of the iliac fossa. An incision was made in the lower part of the tumor, and a small quantity of pus with yellow particles was emptied, which, examined microscopically, proved to be true actinomycosis. Iodide of potassium was given internally, the dose being by degrees increased to 9 grammes daily without any inconvenience; the tumor then began to decrease in size, and disappeared entirely in the course of three months, during which period altogether 300 grammes (9½ ounces) of iodide of potassium were taken.—*Ugeskrift for Läger*, No. 50, 1895.

Diagnosis and Treatment of Renal Calculi.—DR. T. ROVSING, of Copenhagen, in an elaborate article on this subject, points out the diagnostic errors committed in cases of nephrolithiasis, the disease often being mistaken for cystitis, nephritis, etc. He quotes six cases operated on by him to illustrate the different diagnostic difficulties. Pains in the renal or vesical region,—the former, however, not of necessity having the well-known typical character of renal colics,—combined with hæmaturia or pyuria, ought always to arouse suspicion of nephrolithiasis when another cause cannot with certainty be ascertained. The suspicion is confirmed when the history of the patient reveals the existence in his family of other cases of nephrolithiasis, of stone of bladder, of gout, or other arthritic manifestations. Of the greatest importance, however, is the thorough examination of the urine, taken sterile. If the urine is normal the diagnosis of nephrolithiasis can be excluded almost with certainty, while the presence of red and white corpuscles, crystals, albumin, and cylinders (the two latter products in small quantities) favor the presence of nephrolithiasis. Bacteriological examination should be made, to exclude the diagnosis of renal tuberculosis. Cystoscopy and catheterization of the ureters are diagnostic means which are often of the greatest value; the latter is, however, not without danger, and should be utilized as little as possible. If nephrolithiasis is diagnosed, the question of gravel or stone arises,—a question of the greatest importance as to the treatment. The symptoms of gravel are generally periodical attacks of renal colic, with considerable hæmaturia and discharge of gravel through the urine, the patient during the interval feeling well and being without any enlargement or tenderness of the kidneys. A large, fixed concretion, on the other hand, produces permanent or very frequent pains in the renal region or irradiating pains without simultaneous colic or hæmaturia; further, there is constant hæmaturia (macro- or microscopically diagnosed), enlargement of the kidney, and tenderness, the latter being especially of diagnostic value if pressure on the kidney produce the usual pains of which the patient complains. In cases of gravel Dr. Rovsing recommends the daily consumption of 6 glasses of boiled water. In cases of stone the author pleads for early operative treatment, and quotes the case of a patient, aged 29 years, in whom a concretion weighing 148 grammes (4¾ ounces), the heaviest on record in literature, was removed. He prefers nephrolithotomy to pyelolithotomy, and compresses the renal vessels by means of a small, self-retaining compressor.—*Hospitals-Tidende*, Nos. 21 and 22, 1895.

Treatment of Congenital Luxation of the Hip-joint by Lannelongue's Method.—This method (extension combined with injections of chloride of zinc) was tried by J. SCHON, of Copenhagen, in seven cases of congenital luxation of the hip-joint,—the patients being from 20 months to 3½ years of age,—with very satisfactory results. He generally commenced with the injections (2 drops in four different places over and behind the articulation) after two or three weeks of treatment with extension, and repeated them two or three times within ten days' interval. He did not observe any fever or other inconvenience from the injections.—*Ugeskrift for Läger*, No. 34, 1895.

Nephrectomy in Tuberculosis of the Kidney.—E. MULLER, of Aarhus, Denmark, reports the case of a man, aged 35, who for three years had suffered from symptoms of renal disease; the urine contained a great quantity of pus and numerous tubercle bacilli. The right kidney was enormously swollen. Pyelotomy was performed on this kidney and a large quantity of pus was emptied. After this operation pus was constantly discharged through the wound without any mixture of urine, the diuresis continuing to be very fair (1000 to 1200 grammes—32 to 38½ ounces—daily). A month later the diseased kidney was removed and the general condition of the patient now improved immensely; half a year later the patient felt perfectly well and his urine was quite normal. Except for some nodules in the epididymis there were no other signs of tuberculosis in the other organs. —*Hospitals-Tidende*, No. 20, 1895.

Ligature of the Uterine Arteries for Fibromata.—DR. P. KUHN, of Copenhagen, publishes the results obtained by different surgeons in Copenhagen with this method. Professor Howitz performed the operation in 6 cases with successful result in but 1 case, the tumor being but small (the size of a fist) and the patient about 40 years of age. Professor Paulli had 1 case of operation with simultaneous amputation of the cervix, the tumor diminishing to two-thirds of its former case. Prof. F. Levy had 9 cases and is favorably impressed with the operation.—*Nordisk Medicinsk Arkiv*, No. 3, 1895.

Simple Test for Albumin.—Draw up into a small glass pipette or tube about an inch of the urine, let the finger remain tightly over the top and insert the pipette into nitric acid and draw up under the urine about the same quantity of acid, when, if even a trace of true albumin be present, there will appear a beautiful line of demarkation between the acid and urine. This test is as accurate as it is simple and, besides, is decidedly economical and far less troublesome than all others. (A. C. EWING, Salt Lake City, *Medical Record*, March 7, 1896.)

Poland.

DR. J. DRZEWIECKI,

Redaktor Korespondent z działu polskiej literatury tyczącej się: Medycyny ogólnej i lecznictwa; pediatryi; akuszerzyi; ginekologii; laryngologii; otologii; hygieny; demografii; medycyny sądowej; histologii; patologii; bakteryjologii; anatomii; fizjologii.

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w języku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

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Dyspepsia Due to Sexual Causes.—PROFESSOR JAWORSKI, of Krakow, calls attention to a form of dyspepsia in women depending on a sexual cause. In eight cases observed by him examination of the genital organs showed nothing abnormal, and the same was true of the digestive apparatus. There were also no symptoms of hysteria. Six of the patients were young married women who complained of a bad taste in the mouth, nausea, want of appetite, eructations, sense of constriction in the stomach and œsophagus, pressure in the pit of the stomach after meals, salivation, constipation, and vertigo. These symptoms were most marked in the morning. According to the author, they pointed to motor neurosis of the stomach (abnormal peristaltic movements of the stomach and œsophagus and irregular contraction and relaxation of the cardia and pylorus) and depended entirely on incomplete sexual intercourse, to which the patients had recourse in order to avoid having children. In one such case, a woman of 30 years, who had suffered from the symptoms for two years, recovery followed a sojourn at a bathing resort, but recurrence took place as soon as she returned home and resumed her relations with her husband. In two cases the cause was due to too early emission of semen in the husband. Treatment in these cases is of little avail.—*Przeglad lekarski*, January 4, 1896.

Two Rare Cases of Œdema of the Skin.—L. BREGMAN describes the case of a woman, 34 years old, and her daughter, aged 5 years, who, while working in the garden toward the end of May, were both suddenly attacked by symmetrical œdema of the upper extremities, the face of the child being also affected. The skin, except for the pallor, was almost normal, while the general health was good. The œdema reached a maximum in forty-eight hours, and disappeared two days later, leaving behind it ecchymoses on the dorsal surfaces of the hands and on the nose, followed by slight inflammation and shedding of the skin over the affected parts. In two weeks the skin had returned to its normal condition. The author, from a careful study of the cases, concludes that they were due to insolation,—*i.e.*, to the action of the ultra-violet rays on the skin.—*Gazeta lekarska*, No. 44, 1895.

Recurrence of Cancer After Operation.—PROFESSOR RYDYGIER believes that in operating for cancer it is not sufficient to cut out the growth and the lymphatic glands in the neighborhood, but that it is necessary also to remove the lymphatic vessels going from the tumor to the glands, as these may contain the source of future relapses.—*Przeglad lekarski*, No. 3, 1896.

Lactate of Strontium in Nephritis.—DR. BRONOWSKI, having tried this drug in 10 cases of Bright's disease,—3 of acute parenchymatous inflammation, 6 mixed, and 1 interstitial,—does not agree with Dujardin-Beaumetz as to the favorable action of salts of strontium on the kidneys through their diminishing putrefaction in the intestines. Direct experiments with bacteria convinced Dr. Bronowski that the antiseptic properties of lactate of strontium were insignificant, and that the presence of ethereo-sulphuric acids in the urine was not influenced by the use of the drug.—*Medycyna*, No. 1, 1896.

The Anatomy of the Mouth.—PROF. B. DZIERZAWSKI, of the Warsaw Dental College, states that besides the frenula labiorum in the middle of the lips, described in text-books on anatomy, many persons present folds of mucous membrane going from the lips to the gums, and attached opposite the first bicuspids. In order to see these lateral frenulæ it is necessary to draw the corner of the mouth outward and forward with the finger. Of sixty-seven persons examined, the author found them only in five cases, consisting of a single fold from three to five and even eight millimetres high, forming, when the corner of the mouth is drawn forward, a sort of valve, separating the vestibule of the buccal cavity proper from the space between the cheek and the molars and bicuspids. The author believes the condition to be analogous to that observed in cheek-pouched animals, as in certain rodents.—*Gazeta lekarska*, No. 26, 1895.

Russia.

DR. J. DRZEWIECKI,

РЕДАКТОР-КОРРЕСПОНДЕНТ

из области русской литературы, касающейся: Общей медицины и терапіи, педіатріи, акушерства, гинекологіи, ларингологіи, отологіи, гигіены, демографіи, судебной медицины, гистологіи, бактеріологіи, анатоміи и физіологіи.

Всѣ періодическія, медицинскія изданія, сочиненія, стат'и, монографіи и т. д., изданныя на русскомъ языкѣ и касающіяся вышепоименованных предметовъ должны быт' адресованы на имя

Дра Држевецкаго.

87 Краковское Предмѣст'е,
Варшава.

Massage in Gynæcology.—PONOMAREFF, after an experience of three years with massage in the diseases of women, concludes that massage is indicated in the following conditions: 1. Subinvolution after delivery, and especially after miscarriage: massage rapidly diminishes the size of the womb and prevents hæmorrhage and tendency to chronic diseases. 2. Chronic metritis which has not gone on to sclerosis: massage removes stasis and strengthens the muscle of the womb. 3. Abnormal position of uterus and ovaries. 4. Chronic peri- and para- metritis: massage causes absorption of exudations and thinning and absorption of adhesions. 5. As a means of diagnosis in cases in which the limits of the uterus and benign tumors are not distinct. The contra-indications are pregnancy, malignant growths, pyæmia, and septic infiltrations, acute tubal gonorrhœa, blennorrhagica perioöphoritis, and acute fevers. The author makes use of the simplest method,—friction of the uterus over the abdominal wall with one hand, the fingers of the other being in the vagina or rectum, the patient lying on her back with the knees flexed. The sittings are from five to ten minutes in length, and are given daily or two or three times weekly, according to the indications.—*Transactions of the Ural Medical Society*, vol. iv, No. 1, 1895.

Lactic Acid in Corneal Ulcers.—W. DOLGENKOFF used lactic acid in forty cases of ulcer of the cornea, principally chronic. After the application of cocaine 3 or 4 drops of a 50-per-cent. solution were dropped on the ulcer, causing the base and margins to become whitish, the crust falling off on the third or fourth day. The action of the drug was striking, especially in cases accompanied by photophobia and hyperæmia of the cornea. The patients could easily bear light on the second day without experiencing any pain, while the redness about the cornea entirely disappeared. There were no failures in cases of medium intensity, and it was seldom necessary to repeat the cauterization. In six cases of annular ulceration, which is frequently followed by gangrene and incurable blindness, and in two of which the symptoms were alarming, one cauterization sufficed to arrest the progress of the disease. The author highly recommends the treatment on account of its simplicity, which renders it of practical value to country physicians.—*Protocol of the Kursk Medical Society* for 1895.

Leucocytosis in Pneumonia.—PETROFF, who has made a special study of this subject, concludes that leucocytosis is augmented in all cases of croupous pneumonia, being from two to four times greater than normal. The increase begins with the disease, reaching its maximum at the crisis or sooner, and disappearing by crisis or lysis, thus corresponding with the course of the temperature. There is, apparently, a direct connection between the intensity of the inflammation and the degree of leucocytosis. In feeble individuals the leucocytosis is less marked, while in fatal cases it may be present or absent, depending on the strength of the patient and the extent and severity of the disease. The degree of leucocytosis may serve as a guide in the prognosis, as does the constitution and nutrition of the patient and severity of the affection.—*Inaugural Dissertation*, St. Petersburg, 1895.

Ichthyol in Urethritis.—DR. ILYNSKY, from his personal experience, regards this drug as very useful in acute and chronic inflammations of the urethra, whether of specific or other origin. The only inconvenience is that the strength must be gradually increased; beginning with a 2-per-cent. solution, it is necessary to use 6-per-cent. and finally 7-per-cent. solutions after a time.—*Wratsch*, No. 6, 1896.

Clinical Notes and Lectures.

Population Statistics of France.—From the statistics recently issued by the *Office du Travail* it appears that during 1894 there were registered 286,662 marriages, 6419 divorces, 855,388 births, and 815,620 deaths. Compared with 1893 we find a diminution (for 1894) of 632 marriages, 19,284 births, and 51,906 deaths, whereas divorces have increased by 235. The salient point in these figures is—putting aside the feeble diminution (0.2 per cent.) in the marriages and the increase (3.9 per cent.) in the divorces—the backward movement (2.2 per cent.) in the births and a compensatory, but more marked, diminution (6 per cent.) in the deaths. The excess of births over deaths, which in 1893 was 7146, only attained in 1894, despite the fewer births and thanks to the fewer deaths, to 39,768. The following table shows at a glance the annual oscillations of the population since the year 1881 :—

Years.	Marriages.	Divorces.	Births	Deaths.
1881	282,079	. .	937,057	828,828
1882	281,060	. .	935,566	838,539
1883	284,519	. .	937,944	841,141
1884	289,555	1657	937,758	858,784
1885	283,170	4277	924,558	836,897
1886	283,208	2950	912,838	860,222
1887	277,060	3636	899,333	842,797
1888	276.848	4708	882,639	837,867
1889	272,934	4786	880,579	794,933
1890	269,332	5457	838,059	876,505
1891	289,458	5752	866,377	876,882
1892	290,319	5772	855,847	875,888
1893	287,394	6184	874,672	867,526
1894	286,662	6419	855,388	815,620

We thus see that from 1881 to 1889 the births were more numerous than the deaths, the reverse being the case during the years 1890, 1891, and 1892. Since 1892 the births have re-assumed their preponderance; but we perceive that, whereas the births in 1894 were substantially fewer than during the three preceding years (only once, indeed, have the birth figures fallen so low,—viz., in 1890), the increase in the population is really due to decreased mortality. Divorce, which was revived on July 27, 1884, by M. Naquet, the late General Boulanger's henchman and a distinguished chemist, being strenuously opposed by the Roman Catholic Church, is least prevalent where the church is strongest and *vice versâ.* Hence, whereas in the Department of the Seine 51 per 100,000 inhabitants—or, in other words, 258 out of 100,000 households—were divorced, we find in the Lozère only 136 per 100,000 households. Divorce is the most unpopular in Brittany, Berri, the Pyrénées, Savoy, and Auvergne. The general natality for the whole of France is low,—viz., 22.5 per 1000 inhabitants, and 3 births per marriage, the extremes being, in the Gers 14.5 per 1000, and 32.6 per 1000 in Finistère. In the south of France illegitimate births are few in number, while in the north (principally in the Pas-de-Calais, the Somme, the Seine Inférieure, the Eure, Calvados, and especially in Paris) they are considerable and fairly constant. Thus, in 1894 there were 778,937 legitimate as against 76,451 illegitimate births, the corresponding figures for 1893 being 808,110 and 76,562. The general mortality for 1894 was 21 per 1000, the extremes being the Allier (15 per 1000) and the Bouches-du-Rhône (26.9 per 1000). Still-born children numbered 42,046 (24,543 males to 17,503 females),—a fairly constant figure since 1881. The fall in the birth-rate leaves thinking Frenchmen as anxious as ever for the national future, and fully justifies the prophecy that this great country will—say, one hundred years hence—be relegated to the position of a second- or third- rate power. —*Lancet*, February 1, 1896.

Forms of Cataract Symptomatic of Detachment of the Retina.—In a clinical lecture PROFESSOR PANAS states that symptomatic cataract is not an altogether rare affection; it is the final stage of detachment of the retina, which the patients are far from suspecting. The diagnosis should be based upon the following points: The opinion advanced by the patients, that they have been subject to pronounced myopia since their birth or, at least, since a very early age. This is, of course, merely a presumption, but it has a certain importance. Examination of the eye with the finger. If it is soft, flabby, and fluctuating, it is almost certain that there is detachment of the retina. Determination of the visual acuity by placing a lamp or a candle at a certain distance (from five to six metres) from the patient and gradually approaching it. This gives an approximate estimate which may be very useful. Determination of the correctness of projection by means of a candle placed on a level with, above, or below the eye, to discover whether the patient sees the luminous spot thus displaced, and whether there are obscure points in his field of vision. Correct projection, however, does not always exclude the possibility of detachment of the retina. The most striking feature is the objective character of the cataract, which is soft, even fluid sometimes. The crystalline lens has lost its lenticular form and has become round; the iris is pushed outward. Notwithstanding the absence of any visible inflammatory process, there are adhesions; the anterior chamber is obliterated, and, what is extremely curious, the tonus of the eye is not augmented,—a fact difficult to explain. It has been supposed that the tissue of the iris permitted of the filtration of the aqueous humor; but there may perhaps be a more plausible explanation,—viz., that the ciliary process no longer secretes the aqueous humor, as has been observed in certain pathological cases. The modification of the capsule of the crystalline lens is also an important consideration. This capsule consists of a thin transparent tissue presenting extremely curious properties; it shows an extraordinary resistance to alkalies and to the strongest acids,—fuming sulphuric acid for instance,—and also to the various pathological processes. A complete cataract may be present and yet the capsule will retain its transparency. In the symptomatic cataracts under consideration, however, an important modification takes place in the capsule,—its tissue becomes tough and it loses its transparency. These are the cases designated by the older practitioners under the name of "capsulo-lenticular" cataracts, and so rarely are they met with that Malgaigne refused to believe in their existence.

These cataracts are nearly always anterior, and the change in the transparency of the capsule is due to a pathological modification in the subcapsular epithelium, which proliferates, forms various layers, and develops in its most anterior portion true elongated fibroplastic nucleated bodies. It is to-day believed that in certain forms of cataracts embryoplastic cells, true migratory cells, penetrate into the crystalline through the crystalloid. Fatty elements and calcareous deposits are also present, but the most important alteration is this in the epithelial cells, which become cystoid, vesicular; presenting clear spaces and leading to softening of the tissue proper of the crystalline, and the almost fluid cataract. At a certain period the liquid is absorbed, the tissue contracts, and the eye itself becomes reduced to a sort of stump; this is a very frequent termination of detachment of the retina in symptomatic cataract.

Another important lesion which often occurs in the beginning is a kind of destruction of the zonula of Zinn. This zonule, as is known, is composed of ligaments supporting the crystalline; if several of these ligaments become severed, the crystalline is no longer upheld, and dislocation occurs, rarely complete, but sufficient to cause displacement.

It sometimes happens that during operation for cataract the vitreous body protrudes, to the surprise of the operator; yet the explanation is easy. The crystalline being dislocated and the condition not diagnosed, rupture takes place and the eye is lost forever. It is therefore important to determine whether there is dislocation of the crystalline by carefully studying the iris. The patient whose case served as the basis of Professor Panas's lesion showed, at first sight, nothing special, but on more careful examination a point of capital importance in diagnosis could be observed,—viz., *a tremor of the iris.* This tremor was very slight; the iris vibrated like the cord of a guitar lightly touched by the finger; but, however slight this symptom may be, it is a sure sign of luxation of the crystalline lens. It may be claimed that the tremor of the iris cannot occur except where there is a certain space between it and the crystalline, and that hence it is not easy to explain it in the case under discussion, in which the anterior chamber is obliterated, and the iris rests, as it were, on the crystalline. The explanation is very simple. The iris rests on the crystalline, but the latter, owing to the rupture of the zonula of Zinn, has lost its own support; the crystalline thus trembles, and this movement is transmitted to the iris, producing in this way the trembling of the latter.

In concluding the description of these cataracts Professor Panas states that the vitreous body has not become fluid; it has retained its consistency, and has, perhaps, even become slightly more dense.

How must the operation be performed? Above all, the incisions must not be too peripheral, but within the limits of the cornea. They must not be too large. It is necessary to have an experienced assistant, in whom one can have full confidence, who will withdraw the retractor at the proper time. Anæsthesia with cocaine should, as far as possible, be used in this case; it has also the advantage of lessening the tension. In operating upon a child, however, it is preferable to induce complete anæsthesia by means of chloroform. Iridectomy, or at least sphincterotomy, must be practiced without hesitation. The crystalline should be extracted with its capsule. Various instruments are used, but Professor Panas employs the spatula, which he introduces in the beginning behind the crystalline. He loses only a couple of drops of vitreous humor and obtains a very clear pupillary field.

He had occasion to operate upon an elderly notary who had always been decidedly myopic; he had two cataracts, and besides this there was a marked degree of albuminuria (from 5 to 12 grammes—$1\frac{1}{4}$ to 3 drachms—of albumin). Professor Panas did not know that there was detachment of the retina. He removed the entire crystalline apparatus, and it was then that he noticed the detachment. He prescribed glasses and proposed to operate upon the other eye the following year, but found, to his great astonishment, that the detachment of the retina had disappeared. The visual acuity was considerable, the patient being able to read large type,—such as newspaper headings. The speaker noted this case in his records and afterward read that Hirschberg had operated upon a patient in whom the conditions were the same, and that in his case also the detachment had disappeared. The following year Professor Panas operated on the other eye of his patient, and as soon as the incision had been made the crystalline escaped. He immediately performed iridectomy and removed the entire crystalline apparatus. This second operation was less successful than the first, the patient deriving less benefit therefrom. He had recently seen the man, who, after a lapse of three years, was doing well. This case had led the speaker to become a partisan of operation in cases of symptomatic cataract in detachment of the retina: an operation which presents incontestable advantages,—in the first place, it removes a deformity which in some cases may prevent the patient from earning his living, while it sometimes has a beneficial influence upon the pathological condition.

The Amount of Iron in Ordinary Dietaries and Some Articles of Food.—DR. RALPH STOCKMAN makes a valuable contribution to this subject, based on a study of the exact dietary of various persons for one day. In his experiments the whole day's food was treated by heat and acids until all organic matter was destroyed. The residue was then taken up with dilute sulphuric acid, reduced to a ferrous state with zinc, and titrated with potassium permanganate.

The following are some of his results:—

1.	Ordinary diet, Royal Infirmary, Edinburgh	.0093	gramme	iron.
2.	Convalescent diet, Royal Infirmary, Edinburgh	.0060	"	"
3.	Own diet	.0080	"	"
4.	Diet of a healthy young lady	.0080	"	"
5.	Healthy lady, somewhat older, married	.0070	"	"
6.	Nurse, Royal Infirmary, Edinburgh	.0092	"	"
7.	Domestic servant (chlorotic)	.0028	"	"
8.	Factory girl (chlorotic)	.0032	"	"
9.	Same " "	.0013	"	"
10.	Fæces of man on full diet	.0120	"	"

He gives the following results of analyses of several important articles of food:—

1.	1000 cubic centimetres of milk contain		.0038 gramme iron.				
2.	100 grammes	oatmeal	.0031	= .0035	per	100 grammes	dried.
3.	280 "	common bread	.0011	= .00061	"	"	"
4.	100 "	yellow ox-marrow	.0025				
5	40 "	red calf-marrow	.0035	= .0087	"	"	"
6.	120 "	lean beefsteak	.0047	= .0039	"	"	"

The quantity of iron in the daily dietary of healthy persons, with good appetite, averages 0.008 to 0.010 gramme ($\frac{1}{8}$ to $\frac{1}{6}$ grain), while those who eat less ingest about 0.006 to 0.008 gramme ($\frac{1}{11}$ to $\frac{1}{8}$ grain) daily. Four or five pints ($2\frac{1}{2}$ litres) of sweet milk daily suffice to maintain an adult in health, and this amount, according to the foregoing analysis, would contain about from 0.006 to 0.010 gramme ($\frac{1}{11}$ to $\frac{1}{6}$ grain) of iron, while the convalescent diet of the Royal Infirmary, which is certainly a sufficient maintenance for persons leading a somewhat inactive life, furnishes 0.006 gramme ($\frac{1}{11}$ grain) of iron daily. The iron metabolism of the body must be small; very little of the metal can be excreted; the great bulk must be retained in the body and utilized over and over again. About 0.001 gramme ($\frac{1}{84}$ grain) is daily excreted in human urine, while the amount in the bile of dogs is only about 0.00075 gramme ($\frac{1}{85}$ grain). The total excreted by all channels must be extremely small, and is probably well under 0.006 gramme ($\frac{1}{11}$ grain) per day.—*Journal of Physiology*, November 16, 1895.

Double Optic Neuritis After Influenza; Recovery.—DR. CARAGEORGIADES, of Cyprus, sends us details of a case of acute double optic neuritis after an ordinary attack of influenza. The patient, a married woman, aged 35 years, of a neurotic temperament, was seized with influenza of a gastric form; the attack was neither an unusual one nor such as to give rise to any anxiety. The closest examination of the urine yielded no trace of albumin or sugar. On the tenth day the first symptoms which drew attention to the eyes were dimness and photophobia. Three days later pain of a neuralgic character and lachrymation occurred, and in four days the patient was almost totally blind in the left eye; with the right eye only the perception of light was possible. The vision was L = shadow; R = P. L., the pupils being but little dilated and sluggish. There was well-marked optic neuritis in the left eye; much swelling of the papilla extending into the surrounding retina for a short distance, with slight obscuring of the vessels and a few small hæmorrhages. In the right eye similar appearances were noted, but less marked. The author admits that the papillitis was probably due to an intense intoxication from bacterial products of the nervous system and expressed more directly by the neuritis (post-bulbar) in close connection, perhaps, with basal congestion of the brain. The treatment employed consisted of subcutaneous injections of pilocarpine ($\frac{1}{6}$ to $\frac{1}{4}$ grain); instillations of eserine into the eyes; dry and wet cupping, leeches, and blisters to the temple, neck, and behind the ear. Internally, aperients, diuretics, and diaphoretics were given, and rest and protection of the eyes from light were enjoined. In a month's time the sight began to improve; there was much less swelling of the optic discs and less curving of the vessels. The neuritis steadily diminished, and within two months the vision was Jäger 20; on examination the edges of the discs were much more distinct. In three months the discs were absolutely clear and the sight normal. The patient could easily read a specimen of writing corresponding to Jäger 3.

Scoliosis.—PROFESSOR ALBERT stated that Nicoladoni's researches show that the anterior longitudinal ligament is asymmetrical in this affection, being thicker on the side of the concavity and thinner on the side of the convexity, the bone being thick where the ligament is thin and the anterior median line being in the middle of the ligamentous mass. The posterior median line, however, was not determined correctly by Nicoladoni, because he had before his eyes the image of the normal vertebræ, which increase on the concave side in such a way that their ligaments do not give an exact idea of their growth. In the normal vertebra the median line is formed by a vertical spine; in scoliosis the median line is no longer straight, but oblique. The torsion of the vertebræ is due to deviation of the root of the vertebral arch of the body of the vertebra, this deviation taking place at the epiphyseal groove, the remainder of the vertebra being divided in a symmetrical manner by the line of union. In oblique vertebræ a torsion of the bony tissue, and especially of the compact tissue, is observed. In a scoliotic vertebral column, not only torsion, but a true rotation of bony tissue may be noted. The articular surfaces are sometimes thicker on one side, owing to the formation of a layer of bony substance. In looking at a vertebral column affected with scoliosis, one would say that the spinous epiphyses had been arrested in their development, while the growth of the vertebral bodies had been exaggerated.—*Wien. med. Blätter*, December 5, 1895.

Crepitus in Bone Tuberculosis.—PROFESSOR CHR. FENGER, of Chicago, describes a case of joint tuberculosis in which, it having been determined to evacuate the abscess and use iodoform treatment, the patient was anæsthetized. During the application of the anæsthesia the usual nervous tremor occurred, and a sound could be heard all around the operating-table resembling the chattering of teeth, or the noise made by sliding a stick along the palings of a fence, or a cane in the spokes of a wheel in motion, or a woodpecker hammering a tree-trunk, as those surrounding the table variously described it. When the femur was moved with the hand, a similar crepitation was heard, as when two eburnated surfaces are pushed together—a sound like the click of billiard balls. The plan of aspiration and iodoform emulsion could not be carried out, and after the patient's consent had been obtained the joint was opened and the sequestra removed. Dr. Fenger cites another case, occurring in the practice of Dr. Morgan, of Mercy Hospital, in which the same symptom was noted. It is probable that this symptom will occasionally be of use in diagnosticating the presence of eburnated sequestra in tuberculous joints.—*Annals of Surgery*, December, 1895.

Hypertrophy of the Prostate.—The question of the treatment of hypertrophy of the prostate by castration and by resection of the vas deferens is the order of the day. Numerous works have been published on the influence exercised by ablation of the testicles on the volume of the prostate, the majority of which pronounce in favor of the operation. Patients are not always ready to accept the mutilation, however, even though they may be advanced in age, and, in consequence of this fact, surgeons are willing to resort to other means which may effect the same end. Hence the method practiced by PROFESSOR HELFERICH will probably be well received both by surgeon and patient. The operation consists in resecting the vas deferens on both sides. In ten cases in which the author tried this method he witnessed a satisfactory result at the end of two months. Only two of the patients were put under chloroform, the remainder supporting the pain without any effort. The *modus operandi* was as follows: The vas deferens was pinched up with the left hand and the skin incised for an inch; with a blunt instrument the canal was isolated, drawn out the length of six or eight inches, torn off the epididymis, and excised. With a little dexterity the double operation only lasts a few minutes. The wound, treated antiseptically, is closed and covered with collodion. A suspensory bandage is applied, and the patient returns to his occupation. The effect was almost constant in all the cases; micturition was greatly improved, though only in a few instances was the prostate diminished in volume. Professor Helferich does not pretend that resection of the vas deferens equals double castration in efficacy, but it frequently succeeds in improving sufficiently the condition of the patient, and, as it is a benign operation, it deserves to be tried. —*Medical Press and Circular*, February 26, 1896.

Syphilis from an Insurance Point of View.—DR. P. H. MACLAREN, of Edinburgh, in considering this subject without reference to general mortality statistics, from which it is difficult to obtain accurate information, states that he is inclined to classify for insurance purposes all syphilitics under the three following groups:—

1. If a man has been properly treated, the probabilities are that, provided he is of good constitution and habits, no complications will arise, and the expectation would be that he will go through life with scarcely more appreciable risk that one who has never had the disease.

2. If proposer has not undergone a sufficient course of treatment, and applies for insurance before the expiration of six years, the period at which the disease normally terminates, and yet is not suffering from any tertiary manifestations, and is otherwise satisfactory, the chances are that he may escape the malign form, but a 10 per cent. extra should be charged until the expiration of the six years, and the case then reconsidered.

3. When tertiary symptoms have developed, the proposal should be absolutely declined, because, while treatment may temporarily remove these, it cannot eradicate the tendency to recurrence; and clinical observation has shown that those so affected rarely live beyond a term of ten years, and often much less where palliative treatment is not carried out.

While his personal experience is almost absolutely favorable regarding the prognosis of the cases included in Class 1, it is questionable when the cases are looked at, with the interests of the offices perfectly safeguarded, if they should not practically be treated in the same way as those in Class 2. —*Edinburgh Medical Journal*, March, 1896.

Tannoform.—This is a powder composed of *tannin* and *formalin*, found of service by FRANK, of Berlin (*Cent. f. d. gesammte Therapie*, February, 1896), in sixty cases of sweating feet. In almost every case the fetid perspiration disappeared in three or four days.

Recent Suggestions in Therapeutics.

Bicarbonate of Sodium for Common Colds.—DR. L. DUNCAN BULKLEY, of New York (*Medical Record*, January 18, 1896) claims that *bicarbonate of sodium* will control a cold, and asks the profession to give it a careful and fair trial. In commenting on this DR. L. W. ZWISOHN, of New York (*Medical Record*, February 15, 1896), states that he has tried the remedy for the last six years, and has found that it would not only cure a cold, but would also prevent future attacks; not that he kept his patients on bicarbonate of sodium, but he removed the cause, and that was the indigestion. He does not believe that the sodium bicarbonate cures the cold, but it cures the etiological factor, and the cold, which is a symptom of the indigestion, disappears. He has also found that when he cured the indigestion by other means the same good result followed. Following the theory that catarrhal inflammation of the mucous membranes is caused by indigestion, he has tried the same treatment in chronic pharyngitis with very good results.

Carbuncle.—The method of local treatment of this disease which DR. R. M. WEST, of Leicester, has found most successful and rapid is that by subcutaneous injection of some antiseptic fluid. A solution of *pure carbolic acid* in *glycerin*, in the proportion of 1 in 3 to 1 in 8, is used —1 in 5 seems a very useful strength. From 20 to 30 minims (1.3 to 2 cubic centimetres), according to the size of the carbuncle, is injected into the surrounding inflamed indurated tissues, and not into the slough itself. The injections are best made parallel to the edge of the carbuncle, from three to four separate punctures being made in each case; so that, if 20 minims (1.3 cubic centimetres) of the 1 in 5 solution be used, there will be four separate injections of 5 minims (0.32 cubic centimetre) each, each injection containing 1 minim (0.065 cubic centimetre) of pure acid. The needle of the syringe should be introduced about one inch, and as it is slowly withdrawn the injection is pressed out, a string of acid, as it were, being left in the track of the needle. The surface of the carbuncle is then dressed with hot *carbolic-acid fomentations*, 1 in 40, which must be continued until the slough is separated, which usually happens in a week or ten days. The injection causes very little pain and no hæmorrhage; the pain of the carbuncle is usually greatly relieved in a few hours; the temperature almost invariably falls to normal by the following day, the spread of the inflammation is checked, and the induration rapidly disappears. The slough, if there be one, breaks up and comes away in small pieces, and the ulcer left after its separation is of very much smaller size than that left after poulticing or incision. (*British Medical Journal*, March 7, 1896.)

Dry Seborrhœa of the Scalp.—*Beef-marrow*, *oil of sweet-almonds*, *oil of filberts*, of each 10 grammes (2½ drachms); *essence of orange-flowers*, 10 drops. To be rubbed in every night. *Resorcin*, 1.50 grammes (24

Dry Seborrhœa of the Scalp (*continued*).

grains); *essence of wintergreen*, 10 drops; *white vaselin*, 20 grammes (5 drachms). To be rubbed lightly into the scalp once every twenty-four hours. If there be itching: *Chloral*, 5 grammes ($1\frac{1}{4}$ drachms); *lettuce-water*, 60 grammes (2 fluidounces); *distilled cherry-laurel water*, 40 grammes ($1\frac{1}{4}$ fluidounces). To be applied once or twice daily. (HENRI FOURNIER, *Hygiène de la peau et du cuir chevelu.* Société d'Editions Scientifiques, Paris, 1896.)

Iodide-of-Mercury Hæmol.—This is an odorless, brown powder, insoluble in water. It contains 13 per cent. of *mercury* and 28 per cent. of *iodine.* It is best administered in the form of pills, containing 2 to 3 grains (0.13 to 0.2 gramme) each, which may be given at the rate of three a day, making a daily dose of from 6 to 9 grains (0.39 to 0.58 gramme). PROF. J. DIXON MANN, of Manchester, at the request of Professor Kobert, of Dorpat, tried it in some cases of papular syphilides with mucous patches, squamous syphilides (psoriasis), circinate syphilides, syphilitic iritis, and two cases of primary syphilis. Its mildness was shown by the fact that in one or two instances only were any signs of the toxic action of mercury produced, although the drug was continued in many of the cases for several months. The symptoms of mercurialism that did occur were limited to slight swelling of the gums with some increase in the quantity of saliva; on withholding the pills for a few days the symptoms disappeared without treatment, and the pills were then resumed and continued. In four cases slight diarrhœa was produced, which passed away without the pills being discontinued. As regards the action of the drug on the skin diseases and on the other symptoms of the disease for which it was administered, Mann states that it fulfills all the conditions of a mild preparation of mercury and possesses the great advantage that it can be taken for a long time without causing salivation. The iodine that it contains probably aids the mercury in its action on the skin diseases; when the squamous stage is reached, iodide-of-mercury hæmol appears to act more quickly than blue pill or subchloride-of-mercury pills. (*Medical Chronicle*, February, 1896.)

Neurasthenia in Arterio-sclerosis.—Before breakfast each morning a wineglassful of purgative water; a tablespoonful of the following solution every evening: *Bromide of sodium*, 10 grammes ($2\frac{1}{2}$ drachms); *iodide of sodium*, 5 grammes ($2\frac{1}{2}$ drachms); *water*, 150 grammes ($4\frac{3}{4}$ fluidounces). Also give the following pill, two or three daily, at the beginning of the meal: *Extract of hamamelis Virginica*, 0.05 gramme ($\frac{7}{8}$ grain); *ergotine*, 0.10 gramme ($1\frac{3}{4}$ grains). To make one pill. This pill constitutes the base of the treatment and should be continued for some time, with baths and static electricity as adjuvants, according to indications. (RÉGIS, *Jour. de Méd. et de Chir. Prat.*, February 10, 1896.)

Quinine in Typhoid Fever.—DE RENZI and CAPORALI, in a case of typhoid fever in which relapse occurred, gave from 0.50 to 0.80 gramme ($7\frac{3}{4}$ to

$12\frac{1}{2}$ grains) of *hydrochlorate of quinine* hypodermatically daily, with the result that the temperature fell in four days from 39.2° C. (102.5° F.) to 36.8° C. (98.2° F.). The quinine was suspended for one day, when the temperature went up to 38.7° C. (101.6° F.), to fall again definitely when the injections of quinine were resumed. In another case, in which the fever was prolonged, similar injections brought down the temperature from 39° C. (102.2° F.) to 36.7° C. (98° F.), and a similar interruption caused it to rise to 38.3° C. (101° F.), yielding to the injections as in the first case. (*Rivista clin. e terap.*, No. 1, 1896.)

Some Good Expectorants and Cough Remedies.—The following formulæ have been thoroughly tested by Dr. James K. Crook, of New York, in hospital and private practice, and may be trusted to render good service in properly-selected cases:—

1. For irritative coughs: ℞ *Phenacetin*, 20 to 40 grains (1.3 to 2.6 grammes); *ext. glycyrrhizæ*, 20 grains (1.3 grammes); *sacch. albi*, 2 drachms (8 grammes). Fiat pulvis, in chartulas xx dividendus. Sig.: One to be taken at one-, two-, or three- hour intervals.

2. For same of more obstinate character: ℞ *Phenacetin*, 50 grains (3.20 grammes); *ext. glycyrrhizæ*, 20 grains (1.3 grammes); *codeinæ sulphatis*, 2 to 4 grains (0.13 to 0.26 gramme); *sacch. albi*, 2 drachms (8 grammes). Fiat pulvis, in chartulas xx dividendus. Sig.: One to be taken every two, three, or four hours.

3. When an expectorant effect is desired: ℞ *Extracti glycyrrhizæ*, 20 grains (1.3 grammes); *phenacetin*, 20 to 40 grains (1.3 to 2.6 grammes); *ammonii muriatis*, 1 to 2 drachms (4 to 8 grammes); *sacch. albi*, 2 drachms (8 grammes). M. et in chart. xx div. Sig.: One powder to be taken in a little water every two, three, or four hours.

4. A good stimulating expectorant for adults: ℞ *Apomorph. hydrochloratis*, 1 grain (0.065 gramme); *syr. ipecacuanhæ*, 2 fluidrachms (8 cubic centimetres); *syr. Tolutani*, 1 fluidounce (30 cubic centimetres); *aquæ dest.*, q. s. ad 3 fluidounces (90 cubic centimetres). Ft. mist. Sig.: A teaspoonful five times daily at four-hour intervals. Shake well before using. Prepare freshly as required and keep in a dark-colored bottle.

5. A good stimulating expectorant for every-day bronchial and phthisical coughs: ℞ *Ammonii muriatis*, 2 drachms (8 grammes); *Tincturæ opii camphoratæ*, *spiritus chloroformi*, *syr. ipecacuanhæ*, āā 2 fluidrachms (8 cubic centimetres); *syr. prun. Virginianæ*, q. s. ad 3 fluidounces (90 cubic centimetres). M. Sig.: A teaspoonful every three or four hours. Shake well before using.

6. For weak and fruitless coughs with loss of bronchial power: ℞ *Ammon. carbonatis*, 1 to 2 drachms (4 to 8 grammes); *tinct. Tolutani*, 2 fluidrachms (8 cubic centimetres); *syr. senegæ*, *spiritus vini gallici*, *syr. simplicis*, āā 4 fluidrachms (16 cubic centimetres); *aquæ dest.*, q. s. ad 3 fluidounces (90 cubic centimetres). Ft. mist. Sig.: A teaspoonful in a little water every two, three, or four hours.

Some Good Expectorants and Cough Remedies (*continued*).

7. For asthmatic and emphysematous coughs: ℞ *Spiritus ætheris compositi*, 4 fluidrachms (16 cubic centimetres); *potassii iodidi*, *ammon. muriatis*, āā 2 drachms (8 grammes); *codeinæ sulphatis*, 2 grains (0.13 gramme); *syr. Tolutani*, 4 fluidrachms (16 cubic centimetres); *aquæ dest.*, q. s. ad 3 fluidounces (90 cubic centimetres). M. Sig.: A teaspoonful every two, three, or four hours.

8. For recurring bronchitis or winter cough: ℞ *Terebene*, 6 fluidrachms (24 cubic centimetres); *ol. eucalypt.*, 2 fluidrachms (8 cubic centimetres). M. Sig.: Ten to fifteen drops on a little sugar every 3 or 4 hours. (*Medical Record*, February 22, 1896.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Arsberättelse fran Sabbatsbergs Sjukhus I Stockholm för 1893 and 1894. Stockholm, 1895.——Brief Résumé of the Treatment of Appendicitis, by **H. A. Royster**, Raleigh, N. C., 1895.——Case of Induced Insanity, by **A. W. Hoisholt**, Stockton, Cal., 1895.——Some Difficulties in Reference to the Early Surgical Treatment of Appendicitis, by **Carl Beck**, New York, 1895.——The Red Blood-corpuscles in Legal Medicine, by **M. C. White**, New Haven, Conn., 1895.——Autoscopy of the Larynx and of the Trachea, by **M. Thorner**, Cincinnati, O., 1896.——Venous Phenomena, by **A. O. J. Kelly**, Philadelphia, 1896.——The Use of Antitoxic Serum for the Prevention of Diphtheria, by **Hermann M. Biggs**, New York, 1895.——Chronic Perivesical Inflammation, by **L. W. Hotchkiss**, New York, 1896.——Cyst of the Maxillary Sinus, by **Charles H. Knight**, New York, 1896.——Nephritis of the Newly Born, by **A. Jacobi**, New York, 1896.——Some Points in Regard to Sterilization in Private Dwellings, by **Carl Beck**, New York, 1895.——Contribucion al Estudio Clinico de las Diarreas Infantiles, por el **Jose E. Ferran**, de Porto Rico, 1895.——Recto-Vaginal Fistula, by **J. T. Jelks**, Hot Springs, 1895.——Neuritis, by **J. T. Jelks**, Hot Springs, 1895.——Case of Congenital Absence of the Vermiform Appendix, by **J. M. Swan**, Philadelphia, 1895.——The Rational Use of Cocaine in Surgery, by **C. A. Dundore**, Philadelphia, 1895.——Operative Treatment of Aneurisms of the Third Portion of the Subclavian Artery, by **Edmond Souchon**, New Orleans, 1895.——Urethral Strictures, by **Holliday** and **Burton**, Hot Springs, 1895.——Treatment of Fractures of the Lower Extremities in Ambulando, by **Alex. C. Wiener**, Chicago, 1895.——Case of Nephrorrhaphy Performed by Means of Professor Vulliet's Operation, by **Albert Carless**, London, 1896.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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(End of Editorial Department of Journal for April, 1896.)

UROTROPIN.

Urotropin is a derivative of formic aldehyde, and not a coal-tar product. Formic aldehyde, or formalin, possesses well-known antiseptic and preservative power. This knowledge led Nicolaier, of Göttingen, to experiment as to its power of preserving specimens of urine from decomposition pending examination. His experiment proved that neither uric acid nor the amorphous urates were deposited with formalin. On account of formalin being too irritating to use internally, he substituted its amine combination. This substance—hexamethylenetetramine, or Urotropin—is non-poisonous even in considerable quantities, non-irritating, and very soluble in water. A further valuable property of Urotropin is its faculty of combining with salicylic acid and forming a soluble combination.

Dr. Bloom, of Louisville, Ky., states a case he treated with a dosage of 5 grains of Urotropin four times a day, the patient being discharged in four days, cured.

Dr. William Cheatham, of Louisville, Ky., states: "In giving Urotropin I combine it with salicylic acid,—2 drachms of Urotropin and 1 drachm of salicylic acid in 8 ounces of water. A tablespoonful at a dose. The quantity of Urotropin given at a dose would be 8 grains."—*The American Therapist*, New York, January, 1896.

ALBUMINATE OF IRON.

Albuminate of Iron is a preparation that is proving of great help to the physician in treating anæmia. Dr. C. Earle, of Boston, Mass., has given the preparation a very extended trial, and states that "for the last two and a half years I have been using it to the exclusion of every other iron preparation. The blood becomes richer, the hæmoglobin and red corpuscles increase in quantity, and the patient improves in strength and weight. It quickly induces a change and restores matters to their normal condition. Its taste is not objectionable, it is readily digested, does not affect the teeth, and is more prompt in its results than any iron preparation I have ever used."

APOLYSIN IN THE TREATMENT OF HIGH FEVER IN CHILDREN.

Dr. Fisher, in the *Medical Record*, February 22, 1896, gives a very interesting account of his treatment of high fever in children with Apolysin.

As an antipyretic he considers it safer than those usually resorted to. No disagreeable effects were noticeable. He reports eight cases in which the high fever was easily reduced with Apolysin. Apolysin stimulates peristalsis, thus evacuating the infected material from stomach and bowels. Having no cumulative effect, it can be given in large doses.

TREATMENT OF ACUTE RHEUMATISM IN BELLEVUE HOSPITAL.

Dr. H. S. Pearse, in the *New York Medical Journal*, March 14, 1896, states his experience with the new antirheumatic, Salophen. Finding the protracted use of the salicylates to produce gastric and renal disturbances, as well as cardiac depression, he now relies almost exclusively on Salophen. Being free from the toxic principles found in the salicylates, the continued use of the new drug presents no renal or cardiac disturbances. It is likely that extended use of this drug will replace more dangerous methods of treating rheumatism and its congeners.

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Selections from Society Proceedings.

FRANCE.

Société Obstétricale de France, Paris.

Post-partum Hæmorrhage.—M. Tarnier stated that the question of treatment in post-partum hæmorrhage is a vast one, and requires, above all, an accurate diagnosis, for all such hæmorrhages are not of the same origin, being of two categories,—*i.e.*, hæmorrhages from the cervix or vagina and hæmorrhages from the uterus itself. Treatment differs in the two classes. In the former, the diagnosis being made and the vaginal tear recognized, it is seen that the uterus is small, hard, and retracted, and there is no necessity to bring about its contraction. Local compression at the point of injury for a certain period will suffice to arrest the hæmorrhage. Sometimes it is not possible, on account of the presence of considerable quantities of blood, to find the bleeding spot in the vaginal fundus, and it is then best to tampon the vagina as carefully and as antiseptically as possible. This rule also holds good for hæmorrhages due to laceration of the cervix. Theoretically, the best plan is to lay bare the torn parts, throw a ligature around the open vessels, or suture methodically the separated parts; practically needles, ligatures, and sutures are of little vulue, and the tampon only is invariably efficacious.

Hæmorrhages of the body of the uterus are nearly always due to inertia of the muscle, and necessitate a prophylactic, curative, and consecutive treatment. In women predisposed to hæmorrhage after labor—either through disease, as albuminuria, or through individual idiosyncrasy or family tendency—the duration of labor should be shortened as a prophylactic measure. This may be done by rupturing the membranes somewhat prematurely, by extracting the fœtus without delay, and perhaps by giving a little ergotine or ergotinine immediately after expulsion; though on this latter point Professor Tarnier has some repugnance to the use of the remedy, knowing its bad effects.

In the curative treatment—that is, when the hæmorrhage has occurred—retraction of the uterus must be secured. The first and most powerful means, which has always proved successful in his hands, is evacuation of the contents of the uterus, repeated two or three times if necessary. All other methods appear to him inferior. The consecutive treatment, which must follow immediately, consists in hot alcoholic drinks, heat, transfusion, or the injection, subcutaneously or intra-venously, of artificial serum. Tonics and stimulants must be given in the days following the hæmorrhage.

M. Champetier de Ribes had many times realized the value of emptying the uterus to arrest hæmorrhage. Portions of the membranes that may remain in the cavity are sufficient to keep up the hæmorrhage.

M. Bossi, of Novara, called attention to the advantages of hydrastis Canadensis and perchloride of iron, and especially of injections of 1 litre (quart) of salt water every two hours.

Professor Tarnier stated that, besides certain inherent dangers in the use of perchloride of iron, it irritates the mucous membrane and causes adherent clots to form. These render cleansing of the genitals almost impossible.

M. Keiffer, of Brussels, had several times injected perchloride of iron into the arteries, veins, and cavernous tissue, and examined the clot under the microscope, finding that its composition differed from that of true blood-clot. Fibrin was not present, but there was a peculiar precipitation of albuminous elements, forming a friable mass which would favor the production of emboli. It is, therefore, dangerous to provoke the formation of such clots, as they easily disintegrate and may prove disastrous.

M. Maygrier agreed, with M. Champetier de Ribes, that nothing bleeding should be allowed to remain in the uterus, but he did not think it always easy, or even possible, to remove the shreds of membrane with the fingers. In one case of inversion of the uterus he was obliged to detach the membranes, and had the greatest difficulty in doing so, although he had the uterus under his hands and eyes. When the uterus is in place he prefers not to depend on the fingers, but to resort to swabbing out the cavity.

M. Charpentier said that doubtless, as M. Tarnier had stated, there are many cases hereditarily or individually predisposed to post-partum hæmorrhage; but there are also cases of an alarming nature which could in no wise have been foreseen. What is to be done here? All that M. Tarnier had indicated. But there is another procedure, not indicated by him, but which has been of great service to M. Charpentier,—viz., compression of the aorta. In other cases subcutaneous injections of caffeine or ether aided him in cases in which the uterus did not retract.—*La Semaine Médicale*, April 11, 1896.

Académie de Médecine.

Intra-uterine Photography by Rœntgen's Rays.—Professor Pinard presented, in the names of MM. Varnier, Chappuis, Chauvel, and Funck-Bren-

TANO, a note stating that a fœtus *in utero* that had been preserved in alcohol for a long time had been successfully photographed by the X-rays. The uterus had been taken post-mortem in 1894, from a woman who had died of pernicious anæmia when three and one half months pregnant. The specimen measured six centimetres in its thickest portion, and this was traversed by the rays. The photograph showed a silhouette of the body of the uterus with its appendages and the muscular wall; in this dark back-ground the uterine cavity stood out clear, with the silhouette of the fœtus agglutinated to the wall above and to the right.

It thus appears that the double wall of a gravid uterus, hardened by alcohol, can be traversed—the bladder, placenta, rectum, etc.—by these rays, permitting the hope that similar results will be possible in the case of the fresh uterine wall still full of blood.—*La Semaine Médicale*, March 11, 1896.

Treatment of Certain Obstinate Headaches.—M. GALLIARD calls attention to a form of headache which is distinguished from migraine and syphilitic cephalalgia by its continuity, absence of nausea and vertigo, and its cessation at night. It is generally limited to the forehead, rarely to the vertex, occiput, or temples. It generally survives any coincident disorder of the primæ viæ that may exist, and is distinct from the persistent headache of neurasthenia, which, however, it resembles in its resistance to ordinary remedies. M. Galliard claims to have successfully treated a certain number of these cases by the exhibition before breakfast of 0.10 gramme ($1\frac{3}{4}$ grains) of calomel for six consecutive days. On the third or fourth day diarrhœa sets in with some colicky pains. The gums are carefully watched. The headache generally disappears; but, should it persist, a similar six days' course is resumed after the lapse of a few weeks.—*Lancet*, March 7, 1896.

Hiccough Cured by Traction of the Tongue.—PROFESSOR LÉPINE, of Lyons, stated that he had arrested and cured a case of hiccough of four days' standing by drawing the tongue out and keeping it outside of the mouth for a few minutes. He does not know whether the procedure is of any practical utility in such cases, but theoretically it is of interest. It may be asked, if rhythmical tractions of the tongue excite the respiratory centre, as they do in restoring respiration in cases of asphyxia, how can they inhibit this centre, as in the case observed? This apparent contradiction is explained by some experiments made by Professor Lépine in 1876, showing that the result of excitation depends, in the greatest part, on the state of the nervous apparatus concerned; so that, while excitation of the nerves at the base of the tongue will excite the respiratory centre when this is paralyzed, similar excitation will depress it if it is in a state of exaggerated excitability.—*La Semaine Médicale*, February 12, 1896.

SOCIÉTÉ MÉDICALE DES HÔPITAUX.

Uræmic Aphasia.—It has hitherto been maintained that cerebral manifestations of uræmic poisoning were of a general character, proofs of the limitation of the activity of the toxins to a particular area of the brain being wanting. DR. RENDU, physician of the Hôpital Necker, had, however, a case recently in his wards that invalidates this contention. A man, aged 56, was seized suddenly with an apoplectiform attack. When seen on the morrow by Dr. Rendu the man had regained consciousness, but three symptoms remained,—viz., aphasia, right brachial monoplegia, and a systolic bruit at the base. The diagnosis of embolus was made. A few days later, however, the patient was seized with intense dyspnœa, lapsing quickly into Cheyne-Stokes respiration; the urine was scanty and albuminous. Phlebotomy was immediately practiced, the analysis of the blood revealing the presence of 0.75 gramme (12 grains) of urea per litre (quart). It was evidently a case of uræmia. The blood-letting determined an improvement in the condition, the dyspnœa disappeared, and the somnolence gradually diminished, while the vocabulary became more extensive. A month later no trace of either aphasia or monoplegia remained.

MM. MÉNÉTRIER and GUYOT stated that similar instances of uræmic aphasia had come under their notice, but that Dr. Rendu's case was peculiar in that paralysis was superadded.—*Lancet*, April 11, 1896.

CONGRÈS DES SOCIÉTÉS SAVANTES, PARIS.

Treatment of Chronic Alcoholism by Strychnine.—M. COMBEMALE, of Lille, after giving a *résumé* of the history of this treatment, said that it was not against delirium tremens that he employed strychnine, as he believed that isolation, bromides, opium, chloral, paraldehyde, etc., were nearly always sufficient to meet the capital indications,—viz., to bring on sleep. But once insomnia has disappeared—and this is the surest sign that the attack has ended—he believes that the propitious moment for the use of strychnine has arrived. The period of depression will be more or less prolonged; the malnutrition, already great during the acute attack, will increase; all the functions will droop unless a stimulant is found to increase the vital forces, and, usually, alcohol is the stimulant instinctively sought for by the victim, who thus treads in a vicious circle. To avoid this a stimulant other than alcohol must be selected for the patient, and not by him,—a medicine, and not a sort of food. The most appropriate for this purpose is strychnine, as it meets all the requirements rendering its employment necessary. It increases the excitability of the bulbar and medullary reflexes, and thus maintains or elevates the tonus of all the organs, while the psychomotor centres, on the contrary, seem to be depressed in proportion as the medullary centres are excited. The two indications in alcoholism are just those,—viz., to excite the nutritive reactions and calm the cerebral ones.

Again, it is known that individuals anæsthetized by chloroform, ether, bromides, or chloral, feel the effects of strychnine but very slightly, and that the toxic effects of the drug are but little to be feared in them. After an attack of delirium tremens the conditions are about the same; the reflexes are feeble and, the hypnotic agents given during the attack being eliminated slowly, the organism will not react against the depression unless good-sized doses of strychnine are given. The patient accepts the treatment more readily at this time, and, when the beneficial action of the remedy has manifested itself within a few days, he is then the more willing to follow it out.

M. Combemale employs the drug as follows: 0.10 gramme ($1\frac{1}{2}$ grains) of strychnine is dissolved in 20 grammes (5 fluidrachms) of distilled water, and of this solution, each cubic centimetre ($15\frac{1}{2}$ minims) of which contains 0.005 gramme ($\frac{1}{12}$ grain) of strychnine, a quarter of a syringeful is injected under the skin of the abdomen the first day, preferably in the morning, half a syringeful the second day, three-fourths the third day, and an entire cubic centimetre ($15\frac{1}{2}$ minims) the following days, never exceeding this dose. The drug is discontinued only when the first symptoms of saturation appear (sensation of tingling in the extremities), which is generally only about the fifteenth to the twentieth day. After an intermission of eight days the injections are resumed as before, to be suspended and resumed a third and last time. The effects of the treatment are immediate and apparent. The trembling of the extremities is the first symptom to disappear, together with the cardiac tremor, perceptible even in the radial at times and which alcoholics rarely escape. The walk becomes firmer, the appetite returns, and, most important of all, a disgust for alcohol is incontestably established.—*Bulletin Médical*, April 12, 1896.

GERMANY.

XIV CONGRESS FUR INNERE MEDICIN, WIESBADEN.

The Value of Antipyretics.—Binz, of Bonn, discussed the relative value of quinine, salicylic acid, antipyrin, antifebrin, phenacetin, thallin, and alcohol. He stated that until 1867 quinine had universally passed as a drug acting in malaria through its effect on the nervous system. His researches at that time had demonstrated, however, that it was a powerful poison for protoplasm of a lower order, and especially that produced in media in which decomposition of vegetable substances takes place. His experiments had also demonstrated that the antipyretic action of quinine was generally independent of the nervous centres and the circulation, and that the drug exercised a paralyzant action on an inferior organism which was the cause of malarial fever. The discovery of Laveran and the researches of his successors have since shown the exactitude of these assertions. The lowering of febrile temperature in other diseases, as well as in healthy warm-blooded animals, is due to the fact that the activity of the disassimilating cells is directly affected. This fact is demonstrated by experimental evidence (1) that quinine diminishes the number and vitality of the leucocytes; (2) that it diminishes the quantity of nitrogen and sulphur in the urine of warm-blooded animals, whether healthy or suffering from fever; (3) that it lowers their internal temperature when they are submitted to the action of a hot vapor-bath; (4) that in Rubner's calorimeter (which enables one to study the subject of the experiment and the control animal at the same time, and find absolutely similar conditions) under the influence of quinine there is a decreased production of vapor in warm-blooded animals, whether healthy or febrile. Quinine is an antipyretic through the influence which it exercises both on the pathogenic cells which cause malaria and on the cells which form a normal portion of the organism. It has thus a special as well as a general antipyretic influence.

Salicylic acid possesses properties analogous to those of quinine. It is antiputrid and antifermentative, not toxic, and is not destroyed in the human economy. It exercises a special action on the agent, as yet little known, causing acute rheumatism. From this fact, however, it cannot be claimed that salicylic acid, the chemical activity of which is weak, gives as satisfactory results, for in the presence of carbonic acid it abandons its acid. As has been demonstrated, the production of carbonic acid in inflamed tissues is markedly increased. Salicylic acid differs greatly from quinine in other respects; it raises the internal temperatures of animals heated in a vapor-bath, causes an increase of nitrogen in the urine and of leucocytes in the blood. It is thus evident that, though it resembles quinine in its direct action on the etiological factor of a certain disease, it differs from it in regard to its action on the cells of the animal organism, and more nearly approaches the other antipyretics,—as, for example, antipyrin. This latter drug causes a manifest sensation of heat in the entire body when given at the beginning of a catarrhal fever. Zuntz and his pupils have shown that a lesion of the corpus striatum can cause true fever with increase of nitrogen, urea, and sulphur in the urine. The reciprocal action between this fever and the effect of quinine is scarcely perceptible; it is somewhat more marked as regards salicylic acid, and is very distinct as regards antipyrin. The drug acts through the central nervous system,—that is, through the regulating apparatus located in the brain. It is thus a symptomatic antipyretic, but in this respect it possesses a remarkable efficacy in most fevers, and its action consists in the diminishing of an irritation of the central nervous system due to the provoking agent of the fever.

Antifebrin, phenacetin, and thallin appear to act in an identical or, at least, analogous manner. For thallin, however, we must admit, in certain cases of infectious fever, a certain direct action on the pathogenic germs, the activity of which it paralyzes. This is at least true as regards typhus fever, though new researches are necessary to establish the fact more solidly.

As to ethylic alcohol, which until 1889 was considered by almost all observers to cause elevation of temperature in fevers, the researches of Binz have shown that it possesses an entirely different action. In all cases in which it exercises any appreciable influence on the temperature of the animal organism, that influence is always and exclusively an attenuating one. This effect is most marked in the so-called septicæmic, or putrid, fevers. Its antipyretic action in puerperal fever, which must also be classed among the pyrexias, has been clearly established by Breisky, of Prague; Ahlfeld, of Marburg, and Runge, of Göttingen. It acts by increasing cardiac activity, while at the same time its antiseptic effect lowers the vitality of bacteria. It powerfully stimulates urinary secretion and thus leads to the elimination of the toxins which cause and keep up the fever. It is to be noted that the mixture of alcohol and water causes rapid elimination through the kidneys, while pure alcohol has a much less marked effect.

Poehl, of St. Petersburg, suggested the advisability of always associating small doses of a neutral sulphate with antipyretics, so as to facilitate the formation in the organism of sulphuric-ether compounds, which irritate the kidney less during their passage than do the original aromatic combinations. This precaution is all the more advisable, since many reproaches have been made concerning the renal irritation produced by antipyretics.

Von Jaksch, of Prague, called attention to the irritating action of ethylic alcohol on the renal cells. A small dose may cause the appearance of casts in the urine in a person who has never presented them before. The remedy may be employed in moderate doses, but the kidneys must be carefully watched. Quinine is the antipyretic most preferred by the physicians of Prague, who have a considerable number of typhoid-fever cases.

Schill, of Wiesbaden, regarded ethylic alcohol of real value as an antipyretic, and prescribed it for children a year old, in relatively large doses. With the exception of quinine, he was inclined to consider the other drugs as doing more harm than good.

Dettweiler, of Falkenstein, said that, outside of acute fevers, the fever of chronic infectious diseases should also be considered in this connection, especially that of tuberculosis. In an experience in the latter disease, based upon 102,000 doses of antifebrin, of 0.25 gramme (4 grains) each; of 1500 doses of antipyrin, 1 gramme (15½ grains) each, and 8000 doses of phenacetin, 0.5 gramme (7¾ grains) each, administered to patients remaining under his care for several months at a time, he had always noted a manifest relief from the use of the drugs. There were no untoward symptoms, except slight exanthemata and increased sweating. These inconveniences he could avoid by prescribing fractional doses in the form of pills containing 0.05 gramme (⅚ grain) each, from two to six of these being sufficient to bring down the temperature. Naturally each individual case must be treated on its own indications. With these remedies he had been able to cause a return of the appetite, a re-establishment of the digestive functions, and a sensation of well-being, the importance of which cannot be too much appreciated in this disease.

Kast expressed the opinion that, with the exception of quinine, the antipyretics have no value except as symptomatic antinervines to be prescribed from time to time, in moderate doses, to combat symptomatic disturbances. As to antipyrin, phenacetin, and other antithermics, they have in no sense been improved upon by the combinations and various mixtures which have been brought into their preparation.—*La Semaine Médicale*, April 11, 1895.

GREAT BRITAIN.

Royal Medical and Chirurgical Society, London.

Antiseptics in Infantile Diarrhœa.—Dr. J. A. Hayward and Dr. Charles Buttar, in a paper on this subject, made an attempt to justify the use of antiseptics in infantile diarrhœa, in spite of the incomplete, though suggestive, nature of bacteriological researches. Granting this justification, the necessity of forming some conception of the mode of action of bacteria as factors in the causation of diarrhœa was insisted upon before antiseptics could be employed rationally in treatment; otherwise misapplication of the remedy and confusion in noting the results were likely to occur. As a working hypothesis, it was suggested by Dr. Hayward and Dr. Buttar that the mode of action of micro-organisms in connection with diarrhœa might be arranged as (1) irritant, (2) toxic, and (3) infective, the ultimate effect in each instance being brought about by the harmful products of their activity. In support of this classification reference was made to certain food-poisoning epidemics, and their analogy to summer diarrhœa and cholera infantum was pointed out. This classification was a help in deciding when antiseptics might be expected to be of service and when nothing could be expected from them. The best success was obtained by employing them in some of the acute forms of summer diarrhœa and in chronic diarrhœa when bacterial agency might be suspected as a factor in the initiation or prolongation of the disease. The evidence of bacterial agency was then briefly discussed from a clinical point of view, and, if present, how far it might be worth considering in treatment. Experimental researches by Dr. Hayward and Dr. Buttar as to the influence of some of these drugs on the growth in artificial cultivation of proteus, bacillus coli, and the bacillus isolated in the Portsmouth epidemic by Dr. Klein were brought forward.

Dr. Dawson Williams said the profession should be obliged to any one who attempted to introduce order into chaos when dealing with the diarrhœal diseases of infancy; but he doubted if Dr. Hayward and Dr. Buttar had materially advanced their knowledge of the subject, for 99 per cent. of the cases met with in hospitals fell into their second class. The question raised long ago by Pasteur whether an animal could live upon an absolutely aseptic diet had, curiously enough, only been, solved the other day. In Hoppe-Seyler's *Zeitschrift* it is related that an experiment performed with a guinea-pig resulted in success. After a preliminary abdominal section and cleansing the animal was fed on aseptic food and supplied with aseptic air. At the end of nine days the experimenters, worn out with watching, had to kill the animal, but it had meanwhile remained in health, gained weight, and was found afterward to be quite aseptic. A certain amount of discredit had fallen on intestinal antiseptics because those who had first used them had talked of intestinal antisepsis, which was impossible to obtain. In acute summer diarrhœa these drugs were of no use, but in the more chronic forms of diarrhœa they were of great value. He agreed that naphthalin was useful. He had obtained good results from salol, but that drug, so far as the intestine was concerned, was carbolic acid; and he thought that better results could be obtained by the use of carbolic acid itself. He differed from the writers who said that this drug was most useful in the upper intestinal canal, for, on the contrary, he had found carbolic acid most useful in cases which were presumably instances of colitis.

Dr. Kingston Fowler related a clinical experience which he thought should make physicians careful of attributing improvement to the administration of drugs. He was called to see a woman who suffered from severe diarrhœa and a peculiarly offensive odor, which not only impregnated the stools, but apparently came off from every part of the patient's body. He suggested that salol should be given in cachets and the patient should be removed to another house. The patient was removed, but the salol was given in tabloids. In three days the patient was practically well and fœtor had disappeared from the motions, but in the latter all the tabloids were discovered undissolved and unchanged.

The president, Dr. W. H. Dickinson, said that Dr. Hayward and Dr. Buttar had made no mention of foul gases as a cause of diarrhœa. He had seen many cases due to this, and the best treatment was to move the child somewhere else, where there were different water, milk, and air. In the form of diarrhœa associated with very fetid motions he had seen the greatest benefit follow the administration of creasote.

Dr. Hayward, in reply, said that the insolubility of tabloids had driven him back to the administration of fluid drugs. He did not see how the mechanical removal of a child from one house to another would cleanse its intestine of pathogenic organisms.—*Lancet*, March 28, 1896.

Liverpool Medical Institution.

Changes in the Spinal Cord Following Amputation.—Dr. Alfred W. Campbell detailed the changes found in three cases,—one an amputation below the knee and two amputations through the upper arm. For purposes of comparison sections of a spinal cord from a case in which the entire brachial plexus had been injured in early life were shown. In all cases marked changes in the spinal cord were found in those segments which receive the sensory nerves from the skin and give off the motor nerves to the muscles removed. These changes were hemiatrophy, with universal reduction in size of gray and white matter, without definite sclerosis of special tracts, and a numerical deficiency of the nerve-cells in the cornua, but especially in the postero-lateral group of the anterior cornu, all on that side corresponding to the amputation. In the case where the leg had been amputated there was a reduction in the number of the nerve-cells in Clarke's column, in the lower dorsal and upper lumbar segments. The peripheral nerves above the site of operation revealed marked atrophic alterations and a filling up of the intervening spaces between bundles by large quantities of fat. The ganglia on the posterior roots presented atrophy of some nerve-cells. In the brachial-plexus case the hemiatrophy was not so marked and the posterior cornua were symmetrical,—a condition which might be due to the skin being left intact. Reference was made to Sherrington, Head, and Thorburn's work on "spinal localization," and the wonderful accuracy of the results of these observers as confirmed by these cases was commented upon.

Microscopical Preparations.—MR. THELWALL THOMAS read a note on the rapid preparation of specimens for the microscope by the use of formaldehyde in 4-per-cent. solutions, which harden in a few hours any piece of tumor or tissue placed in them. This solution freezes on an ether-microtome, and the sections after immersion in methylated spirit can be readily stained with hæmatoxylin. During the past twelve months he had cut sections (over one hundred) of every tumor or tissue the day after its removal by the surgeon.—*Lancet*, March 14, 1896.

LONDON OBSTETRICAL SOCIETY.

Deciduoma Malignum.—The April meeting of this society was attended by a large gathering of obstetricians and gynæcologists, assembled to hear the experience of experts on a grave subject. The *British Medical Journal* (April 11), in commenting editorially on the meeting, states that two reasons accounted for the large attendance.

In the first place no original communication on deciduoma malignum had hitherto been published in the British empire. The disease was first noted by Sänger in 1888. About fifty original scientific or clinical papers appeared between that date and last year in Germany, France, and Italy. As long ago as 1840 an English writer, Wilton, demonstrated, on the evidence of a case, that the vesicular mole sometimes shows true malignant characters, yet no original communication on deciduoma malignum appeared in the English language until May, 1895, when a monograph was published by an American,—Dr. Bacon, of Chicago. The new case which he reported, however, had been observed not in any English-speaking land, but in Prague. In June an important communication was issued by another distinguished American,—Dr. J. Whitridge Williams. In July, 1895, in the course of a paper on placental polypus, read at the society, Mr. Doran noted the absence of any British report on deciduoma malignum. The particular polypus forming the text of Mr. Doran's paper showed, undoubtedly, placental tissue, yet there was no evidence from clinical history nor from the microscopical appearances how far pregnancy had preceded the patient's death. Hence the histology and pathology of decidua and chorion came under discussion at that time. The subject is one of higher import at the present moment, in view of the question as to what is really to be detected in the metastatic deposits in the lungs, etc., in deciduoma malignum. In January, 1895, Dr. Champneys recorded in the *Practitioner* his experience of some unusual cases of hydatid mole. In one instance he found nodules in the lungs, which made it probable, in his opinion, that the case was allied to those described as deciduoma malignum.

Another reason for the interest displayed is the fact that many suspect that the very term—deciduoma malignum—is misleading, being based on a fallacious interpretation of microscopical appearances,—an opinion brought forward in one of the communications.

Mr. Rutherford Morison, of Newcastle-on-Tyne, contributed an important clinical note on a case where the evidence that metastasis developed in the lung was clinically strong, though, unfortunately, there was no necropsy.

Dr. Herbert Spencer read a very full report of a case under his observation in 1889. By the aid of the magic lantern he demonstrated a fine series of photomicrographs.

A short clinical and pathological report of another case was read by Mr. Malcolm and Dr. Hebb. The pulmonary metastases were very striking, and some microscopical sections were exhibited.

Dr. Eden stated that much doubt exists not as to the malignancy, but as to the decidual character of the primary tumor and the metastases. Professor Sänger first described deciduoma malignum as such, but Dr. Eden doubts that the primary and uterine tumor was made up of decidual cells in Sänger's case. Similar cellular growths, however, have been detected by Dr. Eden and others in the uterus, when their origin could not have been decidual. The same observer showed that it was not made clear, in several foreign reports of this new disease, that delivery or abortion had taken place before its development, while in some cases the primary disease was not clearly determined to be uterine. Thus, in Dr. Whitridge Williams's interesting monograph, it is stated that the patient was attended in her confinement by Dr. W. E. Harris, who prescribed a lotion for a nodule on the right labium majus at the end of a fortnight. A week later he found that there was a rapidly-growing tumor on the labium. When admitted into hospital, a little over a month after labor, the tumor was sloughy, and the patient died two months later. Deposits were certainly found in the uterus and lungs; but the early history points, in Dr. Eden's opinion, to the labium as the primary seat of disease. Dr. Harris, who must have examined the uterus, makes no note of any tumor in that organ.

The supporters of the deciduoma theory base their opinions to a great extent on the appearance in the metastatic deposits of essentially decidual or allied structures; but Eden shows that there is no uniformity of opinion about the minute histology of the fœtal appendages, and that the "syncytium" resembles plasmodia found in sarcoma not related to gestation. In short, the disease known as deciduoma malignum may yet prove to be but a rapidly-growing sarcoma. Pregnancy, so common, may easily coincide with sarcoma of the uterus,—a rare disease which occurs during the child-bearing period. Histology may mislead. A sarcoma is made up of rapidly-growing elements, but so are the normal fœtal appendages. Hence appearances observed alike in normal decidua and in common sarcoma may have been falsely taken as evidence of identity. The truth may be that these appearances simply represented rapid growth.

Royal Academy of Medicine in Ireland.

New Method for Localizing Brain-Lesions.—Mr. Robert Cox pointed out that there was need of a more perfect method of locating the important areas of the cerebral cortex on the overlying surface of the scalp, seeing that most, if not all, of the methods generally employed are either limited in their scope or complicated in their application, while many give rise to error by the use of a standard measure—the inch or the centimetre—for varying surfaces. He thought the method which he was about to describe would be found devoid of these objections. For its use two things were necessary: (1) an instrument which he had invented and called a cerebrographometer, and (2) a diagrammatical map of a hemisphere of the brain, prepared from readings made by the use of the same instrument on the dead body and casts of the brain *in situ*. The instrument consists entirely of the mechanical device technically known as "lazy tongs," formed into a circle with two accessory loops, which latter are attached to the circle by their ends in such a way that they arch over it at right angles to each other. One loop bears the numerals, beginning at each end with 1 and ending in the middle with 10; while the other loop has the letters A and V in consecutive order from before backward, that bearing T forming the junction with the circle behind. The map is made on the gnomonic projection, with the radii, or longitudinal lines, marked by letters, and the semicircles, or lines of latitude, by numerals. In using the instrument it is necessary to extend it in all parts and apply it to the head with the rivet forming the junction of the lettered loop with the circle in front on the glabella, and the rivet marked V at the other end to the occipital protuberance; then press down the loop between these two points in the middle line, and close the circle round the head on such a plane that the numeral 10 will rest on the lettered band. The instrument is then in position, when to find any given point—say Broca's lobe—it is only necessary to consult the map or list of indices for the bearings, there given as "C4, left side," and place the 10 of the numbered loop on the C of the lettered loop, when the numeral 4 will lie over the part. Having thus shown the simplicity of the method, he proceeded to explain that it is applicable to all-sized heads and forms its own unit of measurement for each, thus eliminating the errors due to the use of a standard measure for a varying surface. The two fixed points taken, the glabella and the occipital protuberance, place the circle on that plane considered so important by Professor Fraser as bearing a fixed relation to all important parts of the brain. His opportunities of testing its accuracy were very few, but in those it gave excellent results, while with regard to Rolando's fissure perfection seems to have been reached. In conclusion, he added that the instrument was simple, compact, durable, and capable of being rendered aseptic by boiling.—*Lancet*, March 21, 1896.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

A Case of Histrionic Spasm.—DR. ARTHUR HALL showed a case of histrionic spasm occurring in an elderly man, affecting almost all the muscles of face and jaws. The disease had been coming on insidiously for many years, but had been much worse lately. Violent twitchings of the eyes and facial muscles; spasmodic contraction of the various muscles of mastication, either in the vertical or side-to-side motions, accompanied by profuse salivary discharge, were the most noticeable features of the affection. The patient noticed that when the movements first became violent all his lower teeth on the right side and all his upper on the left side became loose and fell out. When at its worst he could only get to sleep by putting a small prop between his jaws, which fell out when he went to sleep. He can restrain the movements for a short time, but after doing so they become much more violent. The disease seems to be of the nature of a neurosis, and has been much benefited by a course of quinine and iron.—*Medical Press and Circular*, April 8, 1896.

UNITED STATES.

New York Surgical Society.

The Relation of the Weather to Fatality Following Surgical Operations.—Dr. Fred. Walker Gwyer, having had his attention called to this subject by losing a case unexpectedly after a favorable prognosis had been given following an operation for appendicitis, made a study of the records of Bellevue Hospital for the six months beginning January 1, 1895, and ending July 1, 1895, and compiled a list of those cases which died within nine days of operation. While the statistics are too few to warrant a positive conclusion, he thinks that it may safely be assumed that, of the weather indications, humidity is the principal one governing the outcome of operations, and that the barometer, wind, and weather must be considered in relation to it and to possible changes they may indicate. Excessive humidity at the time of injury, whether operative or accidental, is a factor of no little importance in the consideration of the treatment and final result.

The questions that naturally arise are: Why is high humidity so detrimental? How does it affect the body? It appears to Dr. Gwyer that the action is twofold:—

1. In reducing the amount of excretion of the products of metabolism by the lungs and skin. Expired air is loaded to saturation with moisture containing excrementitious material,—principally carbonic acid, but also ammonia and organic solids. If dry air be inhaled the expired air contains 100 per cent. of moisture with its proportion of effete material. If the air inspired contain 90 per cent. of moisture, necessarily but 10 per cent. of the returning moisture is directly from the lungs. If the normal New York air contain 72 per cent., there is left for the lungs, as a means of elimination, 28 per cent. (with no allowance for difference of temperature). As this percentage is reduced, so a corresponding part of the lung-function is interfered with.

So also with the skin, which normally throws off excrementitious material which is increased in amount in dry, warm air and naturally lessened in moist air. Consequently, excessive humidity interferes with the action of the lungs and skin as eliminators, and the excrementitious material remains to poison the system or must be secreted and eliminated by other ways,—notably the kidneys,—thus throwing upon the system and organs, at a time when they can least bear it, a greater amount of metabolic products and a greater amount of work of elimination.

2. Air is a poor and water is a good conductor of electricity. The more moisture the air contains, the greater its conductivity and holding power. Cold air usually means dry air, as, the colder the air, the less moisture it can contain, air at the freezing-point being capable of holding only 2.1 grains (0.136 gramme) per cubic foot, while at 98° F. (36.6° C.) it will hold 18.1 grains (1.17 grammes) (*Climate and Health*, United States Weather Bureau). In cold, crisp, dry air one feels invigorated and filled with surplus energy; in warm, muggy, moist air, just the reverse. Is not this because, in the first case, the electrical potential of the body is high and that of the air low, and, in the second, the potential and conducting power of the air is high, it taking from the body sufficient to equalize or more nearly equalize the potentials, leaving the body deficient, and, as the contact air is continually changing, there is a constant loss of electricity?

If the effects be so noticeable in the normal state, is it not possible that they are still more marked under conditions—such as operation or accident—which, reducing the vitality, cause a reduction of the capability for normal potential; and, under circumstances increasing the potential, capacity, and conductivity of the air, with change from positive to negative, would we not have surroundings very favorable for a rapid, large, and continuous loss of electricity, and the conditions resulting which we now term shock and collapse? In support of this view the author quotes such authorities as Draper, Jenkin, and Tillmann.

As to how these influences of humidity may best be counteracted, Dr. Gwyer suggests:—

1. Postponing operations of magnitude till the weather indications were most suitable. In a large hospital practice, were this done habitually, the work would very soon be in arrears; also, certain cases require immediate operation; but there are a large number of cases (those of disease and chronicity) in which operation might, without detriment, be postponed twelve, twenty-four, or forty-eight hours, or even for several days. The weather returns and indications might be obtained each morning, and, if unfavorable, those cases set for operation, which can be postponed, might be held over till such time as the weather be more favorable.

2. Drying the air. Those cases which require immediate operation and with unfavorable weather conditions, should be operated upon in, and afterward kept in, a dry atmosphere. This could be done easily in a hospital, and comparatively well in a private house, by attention to windows, doors, etc., and elevation of the temperature.

3. Raising the electrical potential of the air and of the body. The dry, warm air supplied in the operating- and reception- rooms will, in itself, serve to do this; further, the electrical potential of the room may be raised by the use of a static machine, and, in addition, a small continuous current might be supplied to the patient.—*Annals of Surgery*, April, 1896.

College of Physicians of Philadelphia.

A Case of Suppuration in the Connective Tissue of the Pelvis Unconnected with Disease of Fallopian Tubes.—Prof. Charles Bingham Penrose stated that suppuration in the connective tissue of the pelvis unconnected with disease of the Fallopian tubes is so rare that a case seen by him seems worthy of report. The great majority of such cases of suppuration arise from infection by way of the Fallopian tube. In a large experience with pelvic inflammation in women he has seen but very few cases in which the suppuration had not such an origin, and he has never before seen a case in which the abscess occupied the position which it occupied in this patient, aged 32, a VI-para. Menstruation began at 16 years of age, and was always regular and painless. Eight months before the report she gave birth at full term to a living child, which, however, died a few days after birth. She suffered with an attack of puerperal sepsis after this labor, for which she was treated in the Pennsylvania Hospital for several weeks. She left the hospital improved, though by no means well. Menstruation was suppressed for the five months following the labor, but for three months had occurred regularly. Since her discharge from the Pennsylvania Hospital she suffered with continuous pelvic pain, most intense immediately above the symphysis pubis and radiating thence to both ovarian regions and the back. This pain increased on assuming the erect position and any motion or jar. She also suffered from irritability of the bladder with pain during and after micturition, the pain being referred to the urethra and to the region of the bladder. She lost in weight and strength.

When admitted to the University Hospital she was considerably emaciated and apparently suffering continuous pain. The irritability of the bladder was so great that she was obliged to urinate every one or two hours. The urine contained a small amount of pus, a few red blood-corpuscles, no casts. The temperature was normal, the pulse weak and rapid. Bimanual examination showed the uterus in normal position, and lying anterior to the uterus and somewhat to the right a dense, hard, inflammatory mass about the size of an orange. The pelvic tenderness was so great that the tubes and ovaries could not be palpated. There was evidently some involvement of the mucous membrane of the bladder, because pressure at the base of the bladder through the vagina caused marked pain.

From the history and the examination it was thought that the woman was suffering with a pelvic abscess, probably of tubal origin and caused by septic infection after labor. On account of the unusual position of the pus some doubts were felt in regard to the tubal origin of the disease.

Cœliotomy was performed in January, 1896. The tubes and ovaries were found normal, nowhere adherent. The omentum and the sigmoid flexure were adherent in a mass to the anterior aspect of the fundus uteri; the bladder was adherent to this loop of intestine and the omentum and the uterus as high up as the fundus. These adhesions were exceedingly strong in character. The examination thus made, through the abdominal incision, showed that the abscess was not of tubal origin, and that in all probability it had originated in the very unusual position in the cellular tissue lying between the uterus and bladder. The abdominal incision was closed, and some days later an incision was made through the anterior vaginal fornix into the abscess-cavity and about $1\frac{1}{2}$ ounces (45 grammes) of pus were evacuated. The woman made a speedy recovery.

The proceeding adopted in this case is one which Professor Penrose has often followed with advantage. The indiscriminate puncturing or incision through the vagina of purulent accumulations in the pelvis certainly seems unscientific, for, if the accumulation is due to pyosalpinx, such incision results in the formation of a persisting fistula, and not in the cure of the disease. Therefore in all cases of pelvic suppuration in women it seems to him most advisable to open the abdomen first and to determine the exact nature of the condition. If a diseased Fallopian tube be the primary cause of the suppuration, this can then be treated through the abdominal incision. If the tubes and ovaries are healthy and the suppuration has occurred, as in the case reported, primarily in the cellular tissue of the pelvis, and is found to be accessible through the vagina, then, of course, vaginal incision is the proper treatment.

Secondary Operation for Tubercular Peritonitis.—DR. ROBERT H. HAMILL reported the following case as well demonstrating the benefit which may be derived in operative interference in some of the cases of tubercular peritonitis. For the sake of comparison he includes in his report the first operation. The patient, a colored woman aged 24, married, with one child, was seen in October, 1894. Menstruation first appeared in her sixteenth year. It was always accompanied with pain, but normal in quantity until after the birth of her child, in 1892, when it became very profuse, frequently lasting for two or three successive weeks. At times it assumed the proportions of a profuse hæmorrhage, she being compelled to remain in bed until its subsidence. Prior to 1892 she was in perfect health, never having been ill from any cause whatever. The first symptom noticed was a well-defined and localized pain in the left ovarian region, rapidly becoming more intense, constant, and general. This was followed by a progressive loss in weight and failure in strength, and when first seen she was a frail, sickly woman, weighing scarcely ninety pounds; a weak, feeble pulse, irregular rises of temperature in the evening, and totally unable to attend to her duties as a seamstress. She was markedly anæmic, and there was alternating constipation and diarrhœa. The family history was good.

A careful physical examination, by Dr. J. P. C. Griffith, gave negative results. Her abdomen was distended by an ascitic accumulation and generally painful. Vaginal examination revealed a retroflexed uterus, normal in size; the right ovary enlarged, and both tubes adherent and tender.

Cœliotomy was performed on November 27, 1894. Upon reaching the peritoneum in making the abdominal incision, it was so much thickened that Dr. Hamill at first thought he had to deal with a cyst-wall rather than the peritoneum, which was three or four times its normal thickness. There was a large amount of fluid within the peritoneal cavity. The omentum was adherent, covering the intestines, and the appendages densely adherent to the adjacent organs. Peritoneum, intestines, uterus, and appendages were thickly studded with miliary tubercles. Nothing was done save to break up the omental adhesions and thoroughly irrigate with sterile water. Convalescence was uneventful, except for a somewhat irregular temperature, ranging from 99° to 102° F. (37.2° to 38.9° C.). The woman left the hospital in four weeks much better, and continued to improve, rapidly taking on flesh and gaining in strength, so that, four months after, she weighed one hundred and twelve pounds,—a gain of twenty-two pounds. In the following July a small ventral hernia developed. This was not operated upon until November 28, 1895,—just one year after the first operation. At this time she had no discomfort except the hernia.

Cœliotomy was performed on November 28, 1895. The peritoneum was normal in thickness. There was no fluid and no tubercles; a very few were seen on the intestines, but on the uterus and appendages they were more numerous,—however, not nearly so many as on the previous occasion. Both tubes were universally and firmly adherent, and were removed with great difficulty. The right ovary, which was as large again as an English walnut, was imbedded in a mass of adhesions and contained a dermoid cyst filled with hair. The abdominal cavity was thoroughly irrigated, the hernia repaired, and the abdomen closed without drainage. Convalescence was perfectly normal. The patient is now able to work and feels perfectly well. The microscopical examination, by Dr. Alfred Stengel, showed the specimens to be greatly thickened tubes. The lumen was patulous, but the walls greatly thickened and cheesy in appearance. The exterior of the tubes was somewhat covered with fibrinous exudate. Microscopically the walls of the tubes were composed of granulation-tissue containing many giant-cells, and in places were cheesy and granular and taking the stain with difficulty or not at all. Tubercle bacilli were not found, but the areas of specific tuberculous granulation-tissue were so characteristic that the disease could be pronounced tuberculosis with absolute certainty. The character of the process—massive caseating tuberculous infiltration—was such as to make it apparent that the tubes were the primary seat of the disease. The outermost limits of the diseased area showed small nodular tubercles,—the secondary manifestations. This, then, seems to have been a case of primary chronic diffuse tuberculosis of the Fallopian tubes. Dr. Hamill's reasons for not removing the uterine appendages at the first operation were twofold: first, the patient took ether very badly and expedition was necessary; and, second, she was in such a weak physical condition that she could not stand prolonged operative interference. The fact of such marked and immediate improvement from the simple opening of the abdomen and thorough irrigation would be a strong factor in determining the extent of the operation, where there was doubt as to the patient bearing a prolonged anæsthetization. However, he does not think it a wise procedure to follow this plan without being fully persuaded that such was the case, for recovery will unquestionably be more complete when the diseased organs are removed.—*American Journal of Obstetrics*, April, 1896.

Clinical Notes and Lectures.

Treatment of Chlorosis.—PROFESSOR POTAIN, of Paris, in a clinical lecture, states that the treatment of chlorosis is rather complex, since the therapeutic indications necessarily vary in the different forms of this affection, being sometimes diametrically opposite. In the interesting form in which the affection is almost exclusively confined to the blood—that is, in which no other lesions or pronounced disturbances of any organ exist—the organism should first be stimulated by means of salt baths, sea-bathing, dry friction, etc. Next in order, as regards therapeutic indications, comes physical exercise, but great care should be exercised not to overdo the matter; while moderate exercise is useful, excessive exercise, on the contrary, is not only useless, but positively hurtful. Intellectual work, on the other hand, exerts a bad influence upon patients of this class, and should therefore be likewise carefully regulated according to the condition of the individual. Thus, young girls will be met with for whom intellectual work, in no way excessive for a healthy man, would be very injurious, because their economy and forces are too weak to endure this work. Nervous excitement and emotion are also harmful for chlorotic subjects, and, sexual excitement being one form of nervous excitement, marriage is not always beneficial in such cases.

It goes without saying that alimentation is an important factor. Strengthening food should be given, but, unfortunately, we are here confronted with two great obstacles: intolerance of the stomach, on the one hand, and intestinal torpor, on the other. In order that the iron be administered in sufficient quantity in the food, the patient would be obliged to take a considerable amount of such food, and here the two obstacles referred to would present themselves. Therefore, in order to attain the desired object, iron must be administered outside of the alimentation. Phosphoric medication is plainly indicated in the form of phosphates, particularly since it is in this form that phosphorus is contained in the tissues. It would seem natural, in order to meet this requirement, to have recourse to foods containing phosphates, such as milk, eggs, beans, lentils, etc. This is quite logical, but here again we meet with the obstacles cited above. The digestive tract is incapable of supporting the large quantity of aliment necessary, and we must therefore again resort to medication. Experiments have been made with acid phosphates, bibasic and others, and it has been claimed that they are not absorbed. This is not the case, as Professor Potain has experimented upon himself and ascertained that the phosphates passed into the urine, and that consequently they were perfectly absorbed, the quantity found being equal to that of the salts ingested.

The stomach does not readily tolerate the phosphates. It has therefore been suggested that they be introduced in vegetables, taking into consideration the well-known fact that phosphorus exerts a powerful action upon vegetation; moreover, it is in this way that phosphorus is introduced into the economy of animals. In man it is a more difficult matter, the essential object being, naturally, not only the introduction of the phosphates, but their utilization in the economy. Hippocrates, and other physicians before him, had resorted to this method of administering the phosphates by means of vegetables. What the ancients called *tisane* was nothing more than a decoction of barley. Hippocrates prescribed this to convalescents and greatly lauded its effects. In truth, this decoction contained a large quantity of phosphates, and in young animals its incontestable action in promoting growth was demonstrated. The phosphates administered in this way form an aliment favorable for the development of the bones. Recently another form—the glycerophosphates—has been proposed by Robin. Experimentation with this therapeutic method is still too limited, however, to allow of any definite conclusions being formulated.

Professor Potain next considered the class of chlorotics presenting cardiac disturbances,—viz., palpitations and cardiac dilatation. In cases in which there is an acceleration of the heart-beats recourse has been had to medicaments diminishing the apparent action of the heart, such as digitalis. These therapeutic agents have very little success in such cases, their action being only temporary ; so that the palpitations recur ; while for some patients digitalis is even hurtful. Dependence should hence not be placed upon these agents, but rather upon those acting upon the nervous system, as bromide of sodium, valerian, camphor, etc.

In some cases cardiac dilatation is accompanied by oppression, dyspnœa, anxiety, nausea, etc. This dilatation depends upon a dyspeptic condition. Therefore, we must direct our attention to the dyspepsia; if we cure this, the dilatation and all the attendant troubles will disappear. Milk diet is of great service in the treatment of this dyspeptic condition, but it should not be inordinately prolonged. On the other hand, it must not be supposed that milk is the only remedy and that it always gives good results. Sometimes, on the contrary, it cannot be borne and its action is injurious. Its effect should be tried before resorting to it exclusively.

Chlorotic dyspepsia plays an important part in the evolution of chlorosis. It may either be primary or secondary. Primary, congenital, or hereditary dyspepsia provokes or favors chlorosis. Therefore, we must turn our attention in this direction as the promoting cause of all the symptoms. What is to be done to suppress or diminish the dyspeptic condition? Alimentation must be regulated, the food selected with the greatest care, and even overprecaution can do no harm. As for the medicinal agents, properly speaking, resort should be had to bitters and alkalines, according as the dyspepsia may result from gastric atony or from hyperchlorhydria. In the latter case the alkalines do not render the service expected of them ; in fact, there are certain cases in which they aggravate the dyspepsia instead of relieving it.

Sometimes the dyspepsia is secondary, forming an integral portion of the chlorosis,—being, in fact, a consequence of the affection. There are some cases, even, in which the dyspepsia takes the lead of all the other chlorotic symptoms. Such cases are a source of great embarrassment. In order that the treatment be properly directed, it is necessary to first diagnose the variety of dyspepsia with which one has to deal, the medication differing according to the variety,—painful, mucous, atonic, etc.

In painful dyspepsia the treatment presents great difficulties, as the stomach is unable to tolerate anything. As we must cure the chlorosis, we are obliged, naturally, to administer iron; we must, therefore, give preference to the form most likely to be tolerated,—*i.e.*, soluble preparations and ferruginous waters. In refractory cases—those unable to tolerate any form of medication—hypodermatic injections may be used as last resort. It has been shown that hypodermatic injections of iron greatly favor the reproduction of the red corpuscles. This is certainly not a method to be preferred, but it is imperative that the intolerance of the stomach be overcome. It has also been proposed to inject defibrinated blood, but the results obtained in this way are not superior to those produced by the iron.

Atonic dyspepsia, in which food is poorly tolerated, is caused sometimes by an insufficiency of hydrochloric acid, and sometimes, on the contrary, by an excess. It has even been claimed that the chlorosis was the result of the hyperchlorhydria, which is not the case. For the cure of this atonic and hyperchlorhydric dyspepsia, alkalines are given; but these may not succeed, and may increase the hyperchlorhydria instead of diminishing it. The best method of combating the affection is by purely hygienic measures, forbidding wine, and being very strict as to the choice of food. This will give much better results than alkaline medication. The use of oxygen is beneficial for such patients. Professor Hayem has demonstrated that inhalations of oxygen act very favorably upon the dyspepsia of chlorotic subjects, causing cessation of the vomiting. Professor Potain has also obtained very good results from its use.

There are cases in which dilatation of the stomach is passive and in no way results from distension. In this condition the food remains a long time in the stomach and causes considerable trouble. To overcome this one may resort to lavage of the stomach, or, if this be not sufficient, to electrization by means of the continuous current, placing the negative pole on the stomach. Electrization may correct the dilatation to a considerable extent.

Patients suffering from dyspepsia with anorexia should rather be classed as neurasthenics; and this neurasthenic condition may lead to lunacy. It is not from lack of appetite, properly speaking, that these patients suffer, but rather from a morbid preoccupation,—a sort of fear of swallowing food. The danger may become great. Therapeutics does not, unfortunately, offer any adequate means for combating this condition. The best thing that can be advised is a change of scene, but too much must not be expected from it.

Two varieties of neuropathic chlorosis are distinguishable: (1) those in which there is atony; (2) those in which, on the contrary, the nervous excitability is exaggerated. The indications differ essentially for the two forms. If you have to deal with the first, atony, you should advise gymnastics, traveling, exercise; all of these are efficacious. If, however, you are treating cases of exaggerated excitability, the means cited may prove injurious. These patients require repose, sometimes rest in bed; the alimentation should be moderate; all fatigue should be avoided. Good results may follow a stay in the country and the use of hydrotherapy, though it is necessary to be prudent in giving douches, beginning with warm water and gradually lowering the temperature.

In another class of cases the chlorosis is complicated by a previous disease. It may be due to intoxication by carbonic oxide, and the ingestion of vinegar, which, as is known, is largely indulged in by young girls with the object of acquiring an interesting pallor. In such cases the indication is very simple; the intoxication must be stopped. The same is the case in malarial fever,—give quinine, arsenic, and prescribe hydrotherapy. In cases in which syphilis is simulated by chlorosis the treatment is even more simple; as soon as the actual trouble has been discovered, the therapeutic measure should naturally be at once directed toward it. The same should be the case in pregnancy, but here the diagnosis is not always easy.

In another group of cases the chlorosis is complicated by tuberculosis, the latter disease being either imminent, owing to the predisposition of the individual, or already present. In the first case therapeutic measures should be most attentively resorted to; hydrotherapy should be dispensed with and arsenic and manganese administered. These two remedies will give good results. When the tuberculosis is not merely imminent, but already exists, two varieties may be observed,—a congestive and a torpid form. When the congestive form is in question, it will readily be seen that, the danger being pressing, all efforts should be directed toward the suppression of this congested state of the lungs. When it is the torpid variety, characterized by great depression, the diagnosis is not easy between tuberculosis and chlorosis. Chalybeates may here be of service.

In cases in which the chlorosis is complicated by heart disease it will also be necessary to distinguish between two forms: (1) chlorosis complicated by aortic insufficiency; (2) chlorosis complicated with true mitral stenosis. In the first instance one must endeavor to enrich the blood by careful treatment. It is well to know that chlorosis, while a regrettable complication of aortic insufficiency, does not tend to aggravate the trouble to any great extent. The benefit derived in such cases from the cure of the chlorosis is, therefore, mediocre with regard to the general condition of the patient and the evolution of the cardiac affection. When there is mitral stenosis the case is entirely different. The chlorosis aggravates the cardiac trouble, and the symptoms are very much improved when the chlorosis has been overcome. Stock reports the case of a woman, suffering from mitral stenosis complicated by chlorosis, whose condition was serious. The ferruginous medication resorted to resulted in the cure of the chlorosis, and so greatly benefited the general condition of the patient that she was able to ride on horseback and even take part in hunts. Ferruginous medication is thus very successful in such cases, owing to the fact that iron acts in the same manner as digitalis. The latter remedy puts a brake, as it were, upon the tumultuous course of the blood; the iron does the same by augmenting the number of red corpuscles, giving rise to a greater resistance on the part of the capillaries, and consequently to a more moderate circulation of the blood.

From these remarks it will be easy to estimate clearly the great importance of establishing the variety of chlorosis in any given case before selecting the therapeutic measures to be employed.

Toxins of the Stomach.—In a lecture delivered at the Jefferson Medical College, Philadelphia, Dr. Fenton B. Turck, of Chicago, states that various symptoms are produced by the absorption of the toxins formed in the stomach. Those of bacterial origin depend upon the groups of micro-organisms and the kind of media or soil in which they develop. The study of the toxins produced from a single species of micro-organism is a fruitless task. The study must be made from the groupings of various forms found in the stomach, both in the normal condition and in diseases of the stomach.

The toxins found in the stomach may be separated into two groups: (1) those formed in digestion,—albumoses and peptones; (2) those produced by bacterial growth. The separation of these two groups of poisons which act as such when injected into animals cannot be satisfactorily effected by any chemical method. By withdrawing the stomach-contents in the morning before breakfast, filtering through a sterilized Pasteur filter, and heating the filtered gastric fluid under a vacuum below the boiling-point to from 140° to 158° F. (60° to 70° C.), certain albumins are coagulated and may be separated from the rest. Cultures of the stomach bacteria for experimental work may also be made by making stroke cultures upon the prepared mucous membrane of the stomachs of pigs or in bouillon prepared from the minced mucous membrane of the pigs' stomach dissected from the muscle-wall. For the purpose of studying the toxins formed in the stomach, especially in gastritis with dilatation, the contents are drawn off in the morning before a meal is taken, or the stomach is washed out at night and the stomach-fluid taken the next morning. In other cases, after cleaning out the stomach, starch only or albumin only, such as the white of egg, is introduced at night and the contents withdrawn next morning in the usual manner. The fluid thus drawn off is filtered through a sterilized Pasteur filter until it is sterile. The contents are evaporated under a vacuum pump and the concentration is measured. One cubic centimetre (15½ minims) to 1000 grammes (2 pounds) of the animal's weight is first injected, and the action carefully noted, with gradually increased "dosage." Separation of the coagulated albumin is then made by maintaining the heat at from 136° to 158° F. (57.8° to 70° C.) for four hours. The fluid is again filtered and the injection made into the animal under the usual aseptic precautions. The cultures made from the stomach and cultivated in the bouillon are treated in a similar way as the fluid taken directly from the stomach. Injections are made into animals and comparisons made of the action.

To illustrate the method Dr. Turck describes the case of a man, aged 35 years, who had gastritis in the first stages, with marked dilatation; 160 cubic centimetres (5 fluidounces) of the stomach-contents were withdrawn in the morning, the patient having fasted fourteen hours. The stomach-contents were filtered through paper and then through a Pasteur filter with the usual precautions and a "control" culture was made. A part of the contents (50 cubic centimetres—1½ fluidounces) was reserved for concentration (50 cubic centimetres—1½ fluidounces—were also reserved for fractional coagulation); that is, to get out the albumoses that would coagulate at 149° and 158° F. (65° to 70° C.) and separate in the manner described. Fifty cubic centimetres (1½ fluidounces) of the stomach-contents left were used for injection into animals just as they came through the Pasteur filter, so as to determine the toxic effect regardless of the composition. To 1000 grammes (2 pounds) of a rabbit's weight, 8 cubic centimetres (2 fluidrachms) produced a paralysis of the hind-legs within half an hour after the subcutaneous injection into the back. It presented the same toxic effect in some respects as is observed in rabbits bitten by venomous snakes: first, a slight tottering movement, then dragging of the hind-legs. After 5 cubic centimetres (1¼ fluidrachms) more had been injected the animal died within three hours. When the concentrated injection from 50 cubic centimetres (1½ fluidounces) to 25 cubic centimetres (6¼ fluidrachms) was used, a somewhat similar result followed, requiring a little more than half the quantity to produce death in the animal. On separating the coagulated albumin in the third experiment there was a difference in the action of the filtrate and the coagulated or precipitated residuum that remained. The filtrate did not show the toxic effect until 25 cubic centimetres (6¼ fluidrachms) were used. The coagulated albumin was placed in sterilized weak acid solution and injected. There was no marked action, except a tremor, until the next day, when the animal died. The post-mortem revealed a pyæmia, probably through infection.—*New York Medical Journal*, February 22, 1895.

The Anatomy of Equino-Varus.—The anatomy of equino-varus has been studied by Louis Lapeyre, who embodies his results in a Paris thesis. The primary condition is, in his opinion, incomplete progressive dislocation of the various joints of the foot, the bony deformity being entirely secondary to the arrested development or increased growth of the parts, brought about by the crowding together of the bones on the plantar and internal surface, and their separation on the dorsal and external surface. From an anatomical stand-point two new facts are brought out by the author: (1) the hypertrophy of the dorsal ligaments, especially the external dorsal, and atrophy of the plantar ligaments; (2) the weakness of the scaphoid insertion of the muscles of the legs. These two points are demonstrated by the invariable presence of bony lesions in congenital club-foot, and the existence of bony obstacles to reduction, which cannot be overcome after the age of 8 or 10 years, but the development of which can, on the other hand, be arrested in the infant. Surgical intervention must, therefore, be complex and take in the various bones. It is indispensable, in order to correct the equinus, to remove the external lateral tubercle of Nélaton, the astragalus in front of the tibial plane, the fibrous tissue uniting posteriorly the fibula and the os calcis. In order to correct the varus it is necessary to remove the head and neck of the astragalus and the great apophysis of the os calcis; to correct the twisting it is necessary to destroy the tibio-fibular posterior attachments of the astragalus and os calcis, and the great apophysis, deviated inward by curving of the bone; finally, to correct the hollow foot, a corner of the bone at the dorsal base must be removed in order to remove the obstacle of the tarsal bones and prevent their crowding on the plantar side. In the child the bony operation may not be required.

Treatment of Apparent Death in the Newborn.—During a period of two years—from December 1, 1892, to December 1, 1894—PROFESSOR PINARD saw, at the Baudelocque clinic, fifty children born in a state of apparent death. Twenty-four were re-animated by clearing the respiratory tract and by stimulation. In a clinical lecture on the subject Professor Pinard urged the importance of these two very simple procedures. As soon as the child is born one of the first duties of the obstetrician is to introduce the finger into its mouth in order to free it of any mucus which may be present and which may interfere with free respiration. Stimulation is quite as important, and a very useful manœuvre for this purpose is friction of the spinal column,—not violent, but nevertheless of a certain force. Very frequently, after several rubbings, the child will open its eyes and make the first respiratory movements. The speaker also touched on the necessity of caution when flagellation is resorted to, as in children with a poor circulation ecchymoses are very easily produced. The greatly-overheated garments usually made use of to envelop a newborn infant are also to be condemned. Professor Pinard observed one unfortunate case in which the child died from extensive burns caused by the use of too hot cloths used to wrap about it.

If the child be not revived by these simple measures insufflation should be resorted to. Chaussier was the first to devise a tube for this purpose, which bore his name. Ribemont afterward modified this instrument, basing himself upon accurate anatomical researches, and gave it the normal curve. The Ribemont tube should be introduced into the mouth and then into the larynx, guided upon the finger; and aspiration should first be performed for the removal of the mucosites and afterward for the insufflations. Unfortunately, this measure presents a certain degree of inconvenience and danger. Professor Pinard is not an advocate of insufflation from mouth to mouth. It is generally supposed that by this method air can with certainty be caused to penetrate into the larynx; very frequently, however, it passes into the stomach instead. He cited, in this connection, a curious case, observed by him, in which the air insufflated into the mouth escaped by the anus. As regards the danger, it consists in the possible production of emphysema consequent upon the rupture of pulmonary vesicles. Though certain observers claim that it is impossible to produce pulmonary lesions by insufflation, he believes these lesions possible, and has by experiments been able to prove their existence. They are easily explainable by the fact that one is dealing with lungs that have not yet breathed, and which are in a condition of atelectasis. When air is insufflated, it does not penetrate equally in all directions,—that is to say, it is not uniformly distributed there will thus be certain vesicles which will be subjected to the pressure of the greater part of the air insufflated, and, when the organic resistance of the pulmonary tissue has been overcome by this pressure, rupture will occur. For this reason Ribemont justly advises that insufflation be practiced very slowly and without effort. Under these conditions insufflation may be considered as the best means for the re-animation of children born in a state of apparent death. This procedure was resorted to in seventeen cases by Professor Pinard, and, though eleven of these died, respiration had nevertheless been induced.

In the six other cases rhythmical traction of the tongue, the process described by Laborde, was resorted to in addition to insufflation. All of these died. In one case the tractions of the tongue provoked respiration when insufflation was ineffectual. In other cases in which respiration was not established, though the heart-beats were perceptible, Laborde's method induced coloration of the skin, but not respiration, and the heart's action weakened. Insufflation was again resorted to, with the result that the heart-beats become more energetic, respiration definitely established, and the children continued to live. It is not, however, to be concluded that traction of the tongue is a useless procedure, and Professor Pinard is far from contesting its great efficacy in adults, and in a case of drowning or hanging he would not hesitate to employ Laborde's method. In children just born, however, whose lungs have not yet fulfilled the function of breathing, traction of the tongue does not appeal to him as being calculated to render any great service.

The Influence of Laparotomy on Tubercular Peritonitis.—K. VASSILEVSKY has made some anatomo-pathological researches on this subject at the Imperial Institute of Experimental Medicine, St. Petersburg (*Arch. des Sciences Biologiques*, vol. iv, No. 3, 1896), and as a result presents the following conclusions: 1. Laparotomy in rabbits modifies the histological structure of tuberculous granulations in the peritoneum by increasing the number of epitheloid cells of the tubercles, or the descendants of connective-tissue cells (stable elements in general), and diminishing the number of leucocytes (unstable elements). 2. Laparotomy, by a process of regression, retards the spread of peritoneal tuberculosis. 3. It favors, to a certain degree, the resorption of products of disaggregation that have accumulated in the tubercle, and diminishes the number of Koch's bacilli. 4. In a certain number of cases it arrests the future extension of the tuberculous process and its generalization in other organs.

DR. JORDAN relates, in the *Beiträge zur klin. Chirurgie* (B. xiii, H. 3), a case showing that dry peritonitis may also be cured after simple laparotomy. The patient suffered from irreducible hernia, necessitating operation. It was found that the hernia had undergone tuberculous degeneration, and the author decided to postpone the radical operation. At the end of a year the hernia had become spontaneously reducible, and the health of the patient was all that could be desired. Jordan concludes that simple laparotomy n these cases leads to rupture of the existing adhesions and resorption of the tubercles. Clinical recovery, however, is not always a synonym of anatomical recovery. The formation of adhesions is not indispensable to cure, as in the majority of cases such adhesions are absent. Jordan cites fourteen cases in which cure was demonstrated either by post-mortem examination or by subsequent laparotomy. In a fifteenth case cure was considered as definite to judge from clinical examination, when a second laparotomy became necessary on account of tuberculous disease of the appendages. It was then seen that the peritoneum was still studded with tubercles. Microscopical examination showed that these were undergoing fibrous degeneration. In view of this fact, Jordan is inclined to believe that the cases described under the name of peritonitis nodosa are in reality cases of tubercular peritonitis on the way to recovery.

Dr. J. Israel, of Berlin (*Deut. med. Woch.*, No. 1, 1896), publishes four cases in which he operated and in which recovery took place. Three of these were children between 4 and 7 years and the fourth a girl of 20 years. The author does not believe that cure is due to evacuation of ascitic fluid, since in two of his cases this was almost nothing, and in a third only 200 cubic centimetres ($6\frac{2}{3}$ ounces). Even intense fever does not contra-indicate laparotomy in these cases, and all except cases of acute generalized miliary tuberculosis are suitable for operation.

Recent Suggestions in Therapeutics.

Acute Tonsillitis.—Professor Grasset gives the following formulæ: Every two hours take a spoonful of *water*, 120 grammes (4 fluidounces); *chlorate of potassium*, 4 grammes (1 drachm). Gargle often during the day with a hot infusion, or with *naphtholate of sodium*, 0.35 gramme ($5\frac{1}{2}$ grains); *hydrochlorate of cocaine*, 0.10 gramme ($1\frac{1}{2}$ grains); *syrup of currants*, 30 grammes (1 ounce); *water*, sufficient to make half a litre (1 pint). Brush the throat two or three times a day with *glycerin*, 30 cubic centimetres (1 fluidounce); *borax*, 4 grammes (1 drachm). If the local condition appear serious, begin by touching the tonsils with a 10-per-cent. solution of *nitrate of silver*, and spray frequently with *carbolized water* or a 1-per-cent. solution of *phenosalyl*. If the pain is too great, especially in deglutition, apply three or four times a day *glycerin*, 30 cubic centimetres (1 fluidounce); *hydrochlorate of cocaine*, 0.50 gramme ($7\frac{3}{4}$ grains). For those subject to tonsillitis with large tonsils, outside of acute attacks, M. Grasset prescribes: Spraying the throat, morning and evening, with 2 teaspoonfuls of the following: *Hydrochlorate of cocaine*, *carbolic acid*, each, 0.50 gramme ($7\frac{3}{4}$ grains); *glycerin*, 200 grammes ($6\frac{1}{2}$ ounces); *water*, sufficient to make half a litre (1 pint). Or thoroughly brushing the tonsils every day or two with *tincture of iodine* and *glycerin* in equal parts. (*Consultations médicales sur quelques maladies frequentes.* Paris: Masson.)

Argentamin in Gastric Catarrh.—RIVA-ROCCI and LEVY (*Morgagni*, No. 6, 1896) substituted *argentamin* for *nitrate of silver* to wash out the stomach in seven cases of chronic gastritis, with hypersecretion of the mucous membrane and in some cases, excess of hydrochloric acid. A solution of 1 to 1000 was used for daily lavage, stronger solutions not being well borne. The first or second time that the remedy was used there was some epigastric pain, but the stomach soon became accustomed to it, and after fifteen days or one month improvement of all the symptoms was manifest. Argentamin modifies the secretion of the mucous membrane, but has no influence on the chemistry of the stomach and does not affect any existing chlorhydria.

Asthma.—FREDERICK P. HEARDER, of Wakefield, Eng., has used *paraldehyde* with good effect in about thirty cases of asthma, including ordinary spasmodic asthma, asthma with epilepsy, with morbus cordis, with renal disease, with chronic bronchitis, and in two cases of asthma with pneumonia. In the majority of the cases relief was rapid and complete, and in the remainder the distress was lessened. The dose employed was 45 to 60 minims (3 to 4 grammes), one dose being usually sufficient, a few cases needing a further dose of 30 to 45 minims (2 to 3 grammes) an hour or so later. The hypnotic action of the drug, also, is of great service, as in so many cases of asthma the attack comes on in the evening or during the night. He has never observed any untoward action of the drug, but, on the contrary, the breathing has gradually become easy and normal and the pulse steadied and strengthened, the patient falling into comfortable sleep. A disagreeable feature of the drug is that it scents the breath strongly for about twenty-four hours. A point in dispensing is that the addition of a few drops of alcohol renders paraldehyde perfectly miscible with water; any flavoring tincture can be used for this purpose. (*British Medical Journal* March 21, 1896.)

Bronchitis.—In bronchial congestion, with scanty, hard expectoration, DR. TYSON has had good results from the use of the following: ℞ *Ammonii chloridi*, 2½ drachms (10 grammes); *syrupi ipecacuanhæ*, 2½ fluidrachms (10 grammes); *syrupi Tolutani*, *spiritus ætheris nitrosi*, āā q. s. ad 2 fluidounces (60 grammes). M. Sig.: Take teaspoonful every three hours. If congestion is accompanied with profuse expectoration, use the following: ℞ *Ammonii carbonatis*, 1½ drachms (6 grammes); *tincturæ ipecac. et opii*, ½ fluidrachm (2 grammes); *tincturæ scillæ*, 1½ fluidrachms (6 grammes); *aq.*, q. s. ad 4 fluidounces (120 grammes). M. Sig.: Take dessertspoonful every three hours. (*Medical World*, March, 1896.)

Cough.—In some considerations with regard to cough and its treatment DR. A. H. BABCOCK states that *codeine* is preferable to *morphine* or *crude opium*, because it rarely disturbs appetite or digestion and is generally free from their unpleasant after-effects. The *phosphate of codeine* is preferable to the *sulphate*, because it contains a larger percentage of the base and is readily soluble and suitable for hypodermatic administra-

Cough (*continued*).

tion. He has used it in cases of *la grippe* with frequent paroxysmal cough with good results. In several cases in which dry, spasmodic, and prolonged cough called for a sedative and antispasmodic remedy he obtained brilliant results from bromoform combined with gelsemium, as follows: *Bromoform*, 7.5 grammes (1⅞ drachms); *tincture gelsemium*, 8 grammes (2 fluidrachms); *syrup of lactucarium*, to make 65 grammes (2⅛ fluidounces); *powdered gum arabic*, a sufficient quantity. A teaspoonful three or four times a day was the dose prescribed. In another case, in which severe and almost incessant coughing, due to acute bronchitis, threatened to break down the heart, already greatly enfeebled from mitral and aortic disease, the following prescription accomplished the happiest results: ℞ *Bromoform*, 7.5 grammes (1⅞ drachms); *codeine phosphate*, 1.0 gramme (15½ grains); *compound syrup of squill*, 10.0 grammes (2½ fluidrachms); *syrup of lactucarium*, to make 130.0 grammes (4⅓ fluidounces); *powdered gum arabic*, q. s. M. et fiat emuls. Sig.: Two teaspoonfuls every two hours. In the very early stage of an acute bronchitis with substernal soreness, *squill* is inadmissible, and the hive syrup of this formula had better be replaced by *syrup of ipecac* or a minute amount of *tartar emetic*. (*Medicine*, March, 1896.)

Dermatol in Blennorrhagia.—CONSTANTINI cured four cases of acute blennorrhagia with gonococci in the pus by means of injections of water containing 2 to 4 per cent. of *dermatol* from one to three times daily. He used no other form of treatment, and recommends the method as being simple and easily applicable in general practice. Dermatol acts as an astringent and cicatrizant, diminishing inflammation, arresting the mucous-membrane secretion, and killing other pyogenic microbes that cause secondary infection. The drug has also the advantage of being neither odorous nor caustic. (*Riforma Méd.*, No. 6, 1896.)

Endometritis.—PENROSE gives the following constitutional treatment for chronic cervical endometritis:—

1. Tinctura four chlorides: ℞ *Hydrarg. chlor. corrosivi*, 1½ grains (0.1 gramme); *liq. arsen. chloridi*, 48 drops; *tinc. ferri chlor.*, *acid. hydrochlor. dil.*, āā 4 fluidrachms (16 grammes); *syrupi*, *aq.*, q. s. ad 6 fluidounces (180 grammes). M. Sig: Teaspoonful in water after meals.

2. Purgatives, perfectly saline preparations, should also be administered: ℞ *Ferri sulphatis*, 12 grains (0.78 gramme); *mag. sulphatis*, 1½ ounces (45 grammes); *sod. chloridi*, 12 grains (0.78 gramme); *acidi sulph. dil.*, 1½ fluidrachms (6 grammes); *infus. quassiæ*, ad 6 fluidounces (180 grammes). M. Sig.: Tablespoonful before meals.

3. Give bromides to control nervous system. Rest must be insisted on. To control uterine bleeding in endometritis the doctor gives: ℞ *Potassii bromidi*, 10 grains (0.65 gramme); *ex. ergotæ fluidi*, 10 drops; *vini ergoti*, 1 fluidrachm (4 grammes). M. Sig.: Take t. i. d. (*Medical World*, March, 1896.)

Enuresis.—Dr. N. E. Norway, of Cornwall, Eng., has had good results in two cases of enuresis by the use of the following prescription: ℞ *Liq. ferri perchlor.*, 2 minims (0.13 gramme); *acidi nitrohydrochlorici dil.*, 2 minims (0.13 gramme); *glycerini*, 10 minims (0.65 gramme); *essence pepsin*, $\frac{1}{2}$ drachm (2 grammes); *aquam*, ad 1 drachm (4 grammes); t. d. s. A similar, but stronger, formula relieved a man, 35 years of age, who had suffered for years from this condition. (*British Medical Journal*, April 11, 1896.)

Lead Poisoning.—Dr. Wood treats chronic lead poisoning as follows: 1. Remove source of poison. 2. Relieve colicky pains by the administration of *belladonna* and *opium*. 3. Relieve constipation by giving *calomel*, 1 grain (0 065 gramme) every hour for five hours, to be followed by a full dose of *Epsom salts* and by rectal injections. If this should fail, give *croton-oil*. 4. To eliminate the lead give *potassium iodide* in 10- to 20- grain (0.65 to 1.3 grammes) doses three or four times daily. 5. If patient is apoplectic, bleed. 6. If patient is anæmic, give *iron*. 7. Restore functions by the use of *strychnine* and *electricity*. (*Medical World*, March, 1896.)

Picrotoxin in Paralysis Agitans.—Berger, of Coutras, relates two cases of paralysis agitans in which he successfully employed *picrotoxin* when classical treatment by *hyoscyamine* had failed. He also cured a case of hysterical tremor by means of *picrotoxin*. (*Méd. Moderne*, April 11, 1896.)

Rhinitis.—Dr. Grayson, of Philadelphia, treats acute rhinitis as follows: The nasal cavity is first cleansed by a spray of *Dobell's solution*. If nostrils are closed by discharges the solution is drawn back into the throat. This is followed by an ointment of: ℞ *Cocaine hydrochlor.*, 30 grains (2 grammes); *menthol*, 40 grains (2.60 grammes); *albolene* (solid), 1 ounce (30 grammes). M. Sig.: Apply by means of an applicator to base of nostril and inferior turbinated bone. This is only temporary, and should be followed by a spray of equal parts of *witch-hazel* and *water*. After the cleansing a powder of equal parts of *stearate of zinc* and *menthol* is used through an insufflator, followed by: ℞ *Thymol*, 10 grains (0.65 gramme); *menthol*, 24 grains (1.5 grammes); *eucalyptol*, 20 drops; *ol. cubebæ*, 40 drops; *benzonol*, 11 fluidounces (340 grammes). M. Sig.: Use as spray. The foregoing local treatment should be supplemented by the following constitutional treatment: ℞ *Quininæ sulphatis*, *ammonii bromidi*, *camphoræ*, āā $\frac{1}{2}$ grain (0.032 gramme); *pulv. opii*, *extract. belladonnæ*, *extract. aconiti*, āā $\frac{1}{10}$ grain (0.0065 gramme). M. Sig.: Take above every hour for two hours; then a third in two hours, and the next day one after each meal. For chronic hypertrophic rhinitis the preliminary treatment is the same as for acute rhinitis,—viz., *Dobell's solution*, *cocaine*, and *menthol ointment*,—to be followed by applications of the following: No. 1. ℞ *Iodini*, 8 grains (0.52 gramme); *potassii iodidi*, 12 grains (0.78 gramme); *glycerini*, 6 fluidrachms (24 grammes). Or, No. 2: ℞ *Iodini*, 12

Rhinitis (*continued*).

grains (0.78 gramme); *potassii iodidi*, 36 grains (2.33 grammes); *glycerini*, 6 fluidrachms (24 grammes). M. No. 1 is to be used first. After the *iodine* use the *thymol*, *menthol*, etc., spray. (*Medical World*, April, 1896.)

Topical Medication of the Stomach.—Pick has published a method of introducing fluids or powders into the stomach so that they are uniformly distributed over the whole mucous membrane. He uses a thin, œsophageal tube 71 centimetres (28 inches) long, which when fluids are to be injected has an extremity with numerous perforations, and when powders are employed it is provided with a pneumatic ball. The stomach is first rinsed with a sound, the end of which is then drawn back to the level of the cardia, and the catheter is introduced through the sound. As the stomach collapses through being empty, air may be introduced before the injection. In chronic gastritis and hypersecretion Pick has in this way applied solutions of *nitrate of silver* varying in strength from 0.1 to 0.5 per cent., and he has also introduced *dermatol* in powder by means of the pulverizator. (*Lancet*, March 21, 1896.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Surgery of the Ureter, by **Christian Fenger**, Chicago, Ill.——Brain Surgery for Epilepsy, by **B. Merrill Ricketts**, Cincinnati, O., 1895.——Camphor-Menthol, by **Seth Scott Bishop**, Chicago, Ill., 1895.——Recent Improved Methods of Infant-Feeding, by **R. Tunstall Taylor**, Baltimore, Md., 1895.——On the Morbid Heredity and Predisposition to Insanity of the Man of Genius, by **Warren L. Babcock**, Ogdensburg, N. Y., 1895.——Two Abscesses of the Brain, by **J. T. Eskridge** and **Clayton Parkhill**, Denver, Col., 1895.——Transactions of the American Ophthalmological Society, Hartford, Conn., 1896.——Four Cases of Mixed or Irregular Forms of Multiple Neuritis, by **J. T. Eskridge**, Denver, Col., 1895.——Primary Lateral Sclerosis, by **J. T. Eskridge**, Denver.——The Disadvantages of Non-absorbable Sutures in Operations for the Radical Cure of Hernia, by **William B. Coley**, New York.——The Indications for Non-operative Local Treatment of Tumors; the Value of Toxins, by **W. B. Coley**, New York.——Modern Surgery of Serous Cavities, by **Merrill Ricketts**, Cincinnati.——Stones in the Common Duct and their Surgical Treatment, by **Christian Fenger**, Chicago.——Operative Treatment of Purulent Disease of the Antrum of Highmore, by **Walter J. Freeman**, Philadelphia.——The Necessity of Early Diagnosis and Efficient Treatment in Some of the More Frequently Seen Orthopædic Affections, by **R. Tunstall Taylor**, of Baltimore.——Prospectus of the Hospital for the Relief of Crippled and Deformed Children, Baltimore.——Infantile Scurvy, with Report of a Case, by **Isaac A. Abt**, Chicago.——A New Adjustable Lamp-Bracket, by **Seth S. Bishop**, Chicago.——Essai sur l'Etat actuel de la Thérapeutique par les Produits physiologiques, en particulier par la spermine, par **W. K. Pantchenko**, St. Petersburg.——Technique of Urethral and Intra-vesical Irrigations for the Abortion of Gonorrhœa and Treatment of Other Genito-Urinary Diseases, by **Ferd. C. Valentine**, New York.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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No. 28, RUE DE MADRID, PARIS, FRANCE.

(End of Editorial Department of Journal for May, 1896.)

HYDROZONE IN PURULENT OTITIS MEDIA.

Dr. William Clarence Boteler, of Kansas City, Mo., reports the following case supposed to involve inflammation of the mastoid :—

"November 4, 1895, I was consulted at my office by a laborer in the Armour Packing Company, aged 24 years, who complained that for about four weeks he had suffered intense pain in his left ear, so severe that it seemed to extend through his entire brain. The man's face was terribly deformed; an œdematous swelling the size of half an ordinary loaf of bread occupied the usual location of the ear. The part was intensely tender and painful. I concluded to withhold a positive diagnosis as to whether it was a case of purulent otitis media or suppurative inflammation of the mastoid. After laborious effort I succeeded in separating the tissue sufficient to introduce a small Eustachian catheter into the external meatus. Through this, with a small rubber syringe, I introduced four times daily ½ ounce of Hydrozone, allowing it later to drain away, advising hot fomentations.

"In twenty-four hours after the treatment the odor, amount, and character of the discharge were lessened, the swelling reduced, and the patient feeling better.

"I continued the introduction of the Hydrozone (through a larger catheter) every hour, allowing it to percolate as deeply as possible into the middle ear.

"This treatment was continued for a week, the man's recovery being remarkably rapid; pain and constitutional symptoms disappeared, his features were normal, and he expressed himself as perfectly well.

"On examination I found a circular perforation in the ear-drum the size of a shot, proving that the case was one of purulent otitis media. Struggling with such cases during a practice of seventeen years, I have never seen the efficiency of Hydrozone equaled by any medicinal or operative procedure."

COCA AND ITS THERAPEUTIC APPLICATION.

Under the above title a valuable monograph lies on our table. Upon a cursory examination of the work we were so impressed with it that we devoted an hour to a careful perusal of its contents. It is finely illustrated. The history of Coca is extremely interesting from a botanical, physiological, and therapeutic stand-point, and the physician possessing this monograph has in a small compass much valuable information to guide him in the use of the various preparations of this Heaven-given plant.

The publication in its entirety is worthy of a careful study by the physician, and can be obtained by applying for it to Mariani & Co., 52 West Fifteenth Street, New York City.

IMPERIAL GRANUM.

Imperial Granum has stood the test of many years and has not been displaced by any food yet introduced, while many competing kinds of prepared foods have come and gone and have been missed by few or none. But this will have satisfactory results in nutrition far into the future, because it is based on merit and proven success in the past.—*Pharmaceutical Record.*

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Selections from Society Proceedings.

FRANCE.

Société Française d'Otologie, de Laryngologie, et de Rhinologie.

Treatment of Adenoid Vegetations.—In a report upon this subject M. Helme gave his ideas upon the curative treatment of adenoid vegetations. The prophylaxis in persons of an hereditary lymphatic disposition, as well as in children who have had infectious diseases acting on the lymphatics, such as scarlatina, measles, etc., is without effect. The only cases in which it is useful are cases of acute coryza followed by adenitis, in which it is possible to prevent the progress of the affection by attention to the general health and to the local lesion. There is no prophylactic means of preventing the development of adenoid vegetations. Medical treatment is insufficient or useless in the great majority of cases. In reality there is but one method of treatment, and that is removal of the growths.

A careful examination should be practiced in these cases, with the aid of anterior and posterior rhinoscopy and the index finger, carefully rendered aseptic. Having ascertained the situation, size, form, and consistence of the tumors and the presence of pus in the naso-pharynx, it is necessary to determine whether there are any other obstructions to respiration, as rhinitis or hypertrophy of the pharyngeal tonsil. These complications have great importance as affecting the indications for operation. When such complications are present, there is an absolute indication to remove the vegetations and await the results. It is not common to see the permeability of the nose become re-established, and, if the tonsils do not undergo regression, a second operation can easily be performed later on.

The contra-indications to removal of adenoid vegetations are but few.

The first is hæmophilia; the second anomalies of the arteries in the nasopharynx, which, according to Moure, are much more frequent than is supposed, and, finally, operation should not be undertaken during family epidemics of whooping-cough, measles, or influenza, nor in cases in which an acute or subacute catarrhal condition of the respiratory passages is present. Local inflammation of the diseased region is not an absolute contra-indication, but rather a cause for postponing the operation until all trace of muco-pus has been removed from the pharynx by means of appropriate treatment. The day before operation injections into the nose should be avoided, and simple applications recommended, as resorcin and glycerin, 1 to 50; insufflations of aristol and sugar of milk in equal parts, and the introduction into each nostril, night and morning, of boric-acid ointment with or without menthol.

The operation varies in technique according as the patient is an infant, a child, or an adult. A child 5 to 7 years of age should be left in ignorance as to the operation, and anæsthetized with bromide of ethyl, 5 to 10 grammes (1¼ to 2½ drachms) being sufficient. The greatest inconvenience of this anæsthetic is that it produces contraction of the jaws. By means of a mouth-opener the jaws can be slightly opened, a tongue-depressor pushed in until the patient gags, when the contraction is over, and the operation can be done either with the curette or with the curette and forceps. The child should be placed on a plane a little higher than the operator, and the thorax should not be compressed by the clothing. The tongue-depressor being in position, the curette is introduced vertically into the cavity, with the extremity to one side; once in the cavity, the knife is turned so as to become horizontal. At this moment the curette is carried to the top of the vault, then drawn forward, as if to press against the choanæ. This second stage, upon which Moritz Schmidt rightly insists, is of capital importance, as it enables one to include the retrochoanal vegetations. In a third stage the curette is lowered by means of a circular movement from above downward and from before backward. A free cut is made with the curette in the median line,—one to the left and one to the right. If necessary, five or six such cuts may be made. The degree of force necessary must be determined by the consistence of the tumors. There may be some difficulty in bringing out all the vegetations removed, and the use of the finger (rendered aseptic) may be necessary to ascertain if all the fragments have come away. If the forceps and curette are used, the former is first introduced, the teeth being horizontal until the pharynx is reached, when they are turned and carried to the vault of the palate, opened as far as possible, then closed, crushing everything that can be seized with them. They are then drawn out, giving a turn with the wrist so as to detach a larger portion of tissue than is included in the blades. If necessary to use the forceps a second time, the cutting parts must be disinfected with carbolic acid 1 to 20. The operation is then finished with the curette as described above.

For nursing infants anæsthesia is not necessary, and Lubet's small, special forceps should be substituted for the curette. In adults insufflations of cocaine are sufficient, the head being held immobile by an assistant.

Société de Biologie.

The Prophylactic Use of Marmorek's Serum before Cataract Extraction in Diabetics.—M. Boucheron had recently under his care a man, aged 70 years, who, passing 46 grammes (1½ ounces) of sugar per litre (quart) of urine, was affected with a streptococcic disease,—lymphangitis of the foot and leg. At M. Marmorek's suggestion 20 grammes (5 drachms) of his antistreptococcic serum were injected. Taking advantage of the consequent attenuation of the vitality of the streptococcus, a cataract was extracted, strict antisepsis being, of course, observed. The corneal wound healed by first intention and the lymphangitis soon disappeared. This preventive treatment may prove useful previously to operation on a diabetic patient, in whom suppurative processes due to streptococcic invasion are very prone to occur.—*Lancet*, May 9, 1896.

GERMANY.

Berliner Medicinische Gesellschaft.

The Serum Treatment of Scarlet Fever.—A paper on the treatment of scarlet fever by Dr. Marmorek's antistreptococcic serum was read by Professor Baginsky, who said that streptococci are often found in scarlet fever, especially in complications and in the septic form of the disease. Dr. Marmorek has not discovered the specific antitoxin for scarlet fever, but he has found that the serum of animals immunized in the usual way by virulent cultures of streptococci has immunizing effects on animals submitted to experiment and a beneficial influence in streptococcic diseases, such as erysipelas and cellulitis. It is inoperative against the special virus of scarlet fever, but Dr. Marmorek believes that it is useful in the streptococcic complications of that disease, if given in repeated and sufficiently large doses till the temperature becomes normal. He has in Paris used this treatment for 96 cases of scarlet fever in which streptococci were found, Lœffler's bacillus being also present in 19 of them. The first injections for the children were 10 cubic centimetres (2½ fluidrachms), but the quantity was afterward raised to 40 and 80 cubic centimetres (1¼ to 2½ fluidounces ; in one instance of pneumonia as much as 90 cubic centimetres (equal to 3 fluidounces) were successfully given. The antitoxin had a specially favorable influence on inflamed lymphatic glands, otitis, and tonsillitis, suppuration being sometimes prevented. Professor Baginsky then gave an account of the results obtained by himself in the treatment of 57 cases of scarlet fever, both with and without complications. Nine of those cases ought properly to be disregarded, partly because the treatment was interrupted by failure in the supply of serum and partly because the patients were actually moribund when the serum was used. The other 48 cases may be divided into three groups. In the first, consisting of 27 patients, the treatment was begun in the first stage of the illness ; there was a rapid improvement after the injection of from 10 to 30 cubic centimetres (2½ to 8 fluidrachms) and no complications ensued. Professor

Baginsky, however, remarked that mild cases are not rare, even in the absence of any treatment. In a second group the antitoxin was also administered from the beginning, but the results were much less satisfactory. Of 16 patients, 6 died with general sepsis or septic complications and the remainder suffered from severe otitis, glandular suppuration, nephritis, etc. It is possible, however, that these unfavorable results may have been due to an insufficient quantity of serum having been used. In the third series, consisting of 5 cases, the antitoxin was administered not from the beginning, but during the course of the illness. One of these patients died from otitis, with thrombosis of the sinus; in another the submaxillary gland suppurated and had to be opened, while in the 3 remaining cases a favorable influence on the temperature was probable. Taking the whole series, there were 7 deaths among 48 patients, or a mortality of 14.6 per cent.,—a relatively good result compared with the average mortality of this year's epidemic, which has been about 30 per cent. Professor Baginsky was of opinion that it would be premature to form a definite opinion as to the usefulness of the remedy, but there is sufficient justification for giving it a trial.—*Lancet*, May 9, 1896.

GREAT BRITAIN.

British Laryngological, Rhinological, and Otological Association.

Rœntgen Rays in Laryngeal Surgery.—Dr. John Macintyre read a paper on this subject, and demonstrated the rays, apparatus, etc. The question naturally arose whether this important discovery would be of use in this special department. He had been making a number of experiments in this direction, of which he gave preliminary notes. As regards apparatus for cryptoscopical purposes,—and this must in the end be of more importance than photography,—more expensive and powerful apparatus must be at the surgeon's disposal. For this work a current of something like 10 volts and 12 to 16 ampères at least was required, and a good coil with a well-made interrupter, having a spark of from six to eight inches, and a Crookes tube at the proper vacuum. For photographic purposes the current need not be so powerful, and even a two- to four-inch spark coil might be used for most practical purposes. During his experiments he had been fortunate in having currents and coils of much greater strength than the above-mentioned. His work had been mainly done with an Apps coil, and the best results had been obtained with Newton's tubes. He had tried a number of fluorescent screens for the cryptoscope, but found the potassium platino-cyanide and barium platino-cyanide the best. Calcium tungstate in its crystalline form, as recommended by Mr. Edison, was also good. With this apparatus the author had been able to see shadows of the different bones of the extremities, the vertebral column, ribs, clavicle, and scapula. In the present state of our knowledge it might at once be stated that photography by means of the Rœntgen rays was in a more advanced state than cryptoscopy. With regard to the former, he had in the living subject photographed the vertebral column in the chest and neck (above and below the lower maxilla) with such definition that destruction of bone would easily be detected. He had also photographed the chest for the presence of foreign bodies, and he had been able to photograph the larynx in the human subject, the picture obtained showing the base of the tongue, hyoid bone, thyroid and cricoid cartilages, with epiglottis ; the opening at the upper part of the œsophagus was also seen, and the spine was indicated behind. He had also photographed the bones of the face in health and disease, in the latter case showing destruction of the upper jaw, the result of malignant disease. Experimenting on the dead subject, he had been able to obtain excellent photographs of foreign bodies in and around the region of the larynx, as well as ossification in the cartilages. With regard to the cryptoscope, the light easily penetrated the tissues of the neck and chest, and he had seen sufficient of the former to enable him to say that many foreign bodies might be detected with the eye without photography at all. In this department he had to record an interesting case sent to him by Dr. Rutherfurd and Prof. Henry E. Clark. The patient had swallowed a half-penny six months ago, and on examining him by means of the fluorescent screen the author could easily see the round, black shadow of the coin at the level of the third dorsal vertebra. This was important and interesting because the boy referred his pain to the cardiac orifice of the stomach. He afterward photographed the case, but the foreign body could as easily be seen by the eye. For the examination of the antrum of Highmore he had made a number of experiments in the way of obtaining small tubes to go into the mouth. These were not so easily obtained nor as yet so satisfactory as the large tubes. He therefore fell back upon another plan,—namely, placing the Crookes tube outside. He made a small laryngo-cryptoscopical mirror and a cryptoscopical tongue-depressor, the salt being placed on one side of the glass cut to the proper size and shape, and covered in with aluminium. In this case the X-rays were generated outside the mouth. For the antrum, where difference of density was to be detected, the tube must, of course, be placed above the level of the face and the mirror inside of the mouth with the platinum surface toward the palate. In the case of foreign bodies or for viewing other parts of the mouth the Crookes tube would be placed below the lower maxilla.—*British Medical Journal*, May 2, 1896.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Plastic Surgery in Ablation of the Breast.—MR. MAYO ROBSON, in a paper on a method of obtaining a complete skin-covering after ablation of the breast, remarked that in complete ablation of the breast and of the skin covering it a difficulty frequently arose when the effort was made to obtain a skin-covering, this being, as a rule, impossible without further operative treatment. So far as he could ascertain, the general practice among surgeons had been to draw the parts together as far as possible and then to leave the remainder to granulate or to cover the remaining surface by Thiersch's skin-grafts, the former being a tedious and the latter an uncertain and not always successful method. He showed that by means of one or two single incisions with sliding of the flaps the whole of a very extensive wound might be closed, and that primary union might thus be secured. Although some tension was necessarily present, the observance of antiseptic precautions had prevented sloughing, and in a number of cases on which he had operated he had not experienced any trouble. He believed it would be found that adoption of the method portrayed, or some modification of it which would carry out the principle of completely recovering the large wound-surface, would not only render these extensive operations less formidable by shortening the convalescence, but would tend to greater thoroughness, as it would also enable surgeons to operate on cases otherwise hopeless.

Mr. Butlin, with whom was associated Mr. Beadon Adams, read a paper on the transplantation of skin-flaps for the filling up of considerable defects after amputation of the breast. In cases in which it was necessary to remove large areas of the integument in operations for cancer of the breast, rapid healing of the wound and subsequent contraction might often be prevented by transplantation of flaps of skin in the immediate neighborhood of the wound. He had employed this method in fifteen or more cases and had generally employed the method of transplantation by rotation. The flaps should not be more than three and one-half or four inches in length. They should have large bases. Flaps were more easily procured on the lower margin of the wound. Asepsis was not the only condition necessary to insure the vitality of the flaps. The best cases for transplantation and the best scheme of transplantation for the majority of cases were discussed. Mr. Butlin had found that tension on the flaps was of comparatively small importance in determining sloughing.

Mr. W. G. Spencer said that for nearly all cases in which there was not enough covering after removal of the breast the lower flap should be undermined to a much greater extent than was commonly done. The undermining could be carried down to the lower ribs and behind to the angle of the scapula. This not only gave an extraordinary amount of room, but in this way ulceration of a flap was avoided from the twisting of its pedicle. The undermined flap might, if necessary, be button-holed at its lower portion to prevent accumulation of blood.

Mr. Watson Cheyne was able to confirm the last speaker's observations. He always removed a large amount of skin in amputation of the breast—all that which lay over the prominence of the breast. At first in these cases he performed skin-grafting, but afterward he found that undermining was a better procedure. He carried this out in all directions, quite up to the neck and down to the abdominal muscles, and he drew the edges together with stout silver wire passed at a distance of about an inch from the edges of the flaps. The only condition necessary to enable this manœuvre to be carried out was that the wound should be oval. The stitches of relaxation would sometimes cut through, but this made no material difference to the result. In about 10 per cent. of the cases in which stitching together by these means could not be done he had employed flaps and skin-grafting. An objection to the operation by flaps was that the patient was already often collapsed after an extensive dissection of the region of the breast, and the plastic proceeding certainly added considerably to the length of the operation. In such cases, where collapse was present, he stitched the wound together as much as possible, and then in three or four days skin-grafted the remainder of the wound. Cases treated in this manner did very well indeed, and he had very few failures after skin-grafting.

Mr. Wallis remarked that in plastic operations about the face he had seen the flaps become very congested and threaten to slough, but this had been prevented by multiple pricking of the flap. The objection to the application of this method to the breast was that it involved the exposure of the wound.

Mr. Barwell was in the habit of using large lead-button sutures where the tension was greatest, and he frequently relieved the stretching by making incisions parallel to the wound edge and then sewing these latter up in a direction at right angles to the wound-edge. As he believed that the resistance was chiefly in the subcutaneous tissue, he was careful to divide any prominent fibrous bands that presented themselves.

Mr. Bowlby said that the patients appeared to suffer more pain when the flaps were dragged together, and that the patient was more hide-bound with the dragging than with the flap method. Cases in which the tumor extended toward the clavicle or toward the sternum were more suitable for flaps, while the wounds extending toward the axilla came together better by dragging.

Mr. Mayo Robson, in reply, said that it was only in the exceptional cases that he used the flap method, and he agreed that in all cases undermining and dragging were better where possible, taking care that in all cases where dragging was resorted to the stitches should be placed well away from the edge of the wound. In his flaps he took the whole thickness of the tissue, and he had done it in stout people, as well as thin ones, without producing sloughing. He used no drainage whatever.

Mr. Butlin, in reply, said that his flaps appeared to be much like Mr. Mayo Robson's except that in very fat people he thought it better to take skin only. The flap method avoided the necessity of skin-grafting, which was to the patient a second operation. The after contraction by the flap method was small, and the upper extremity could be moved with ease.—*Lancet*, May 2, 1896.

London Clinical Society.

Laryngectomy.—Mr. E. Ward, of Leeds, described the main feature of this operation, which he had practiced in three cases, as the complete shutting off of the wound from the mucous canals opening into it. This method, in favorable cases, resulted in union by first intention throughout the whole extent of the wound. No preliminary tracheotomy was required where not already rendered necessary by urgent dyspnœa. The first part of the operation was carried out on the ordinary lines, the larynx being, in preference, separated by division of the crico-tracheal membrane and dissection from below upward, enucleation of the upper part being thus facilitated. In cases of intrinsic disease the opening into the pharynx need not be more than a small, vertical slit. After the larynx had been removed a large tube was passed from the mouth into the stomach, and the cut edges of the pharynx were carefully brought together over it by closely-set sutures of fine silk, the pharyngeal wound being entirely closed. Then two half-discs of skin were cut out of the edge of the flaps opposite to the tracheal aperture, which was closely stitched to the circular opening thus made, and the skin-wound was closed by suture throughout. Drainage-tubes were inserted at each end of the cross-incision at the upper part. By this method of closing the wound the trachea and pharynx were completely shut out from it, and the trachea was so held open that no tracheotomy tube was required. The œsophageal tube was removed or left *in situ* for feeding, according to the requirements of the case and the difficulty with which it was passed. Three cases in which the operation was performed were related. In two (a man, aged 64, with epithelioma, and a man, aged 42, with dyspnœa and dysphagia) it was successful; in the third (a child with laryngeal papillomata) the patient died sixty hours after the operation. Mr. Ward claimed for this operation (1) that it would reduce the mortality; (2) that it would shorten the convalescence; (3) that it would add immeasurably to the comfort of patients during convalescence and after recovery; (4) that it would justify attempts at radical treatment in some cases in which this was at present considered inadmissible.

Dr. F. Semon said there were two observations made by the author from which he must dissent: 1. That in regard to serious operations, such as laryngectomy, the subsequent general condition of the patient need not concern the surgeon. The patient should decide whether he would undergo operation to prolong his life, but with some subsequent serious disability, which should be fully described, or whether he would be left to die sooner without operation. 2. He protested against the performance of laryngectomy for papilloma of the larynx in a child. The disease was quite amenable to other milder methods of treatment. Had the child survived, what would have been its condition through life without a larynx? A prophylactic tracheotomy, with removal of exuberant masses of the growth, would have sufficed. Indeed, with a combination of general chloroform narcosis and local cocaine anæsthesia (as suggested by Dr. Scanes Spicer), it was possible to remove such growths, even in children.

Mr. Arbuthnot Lane had performed an operation very similar to that described by Mr. Ward, which was very useful. In a case of papilloma of the larynx where recurrence took place after removal of the growths, he gave arsenic freely, that remedy effecting the removal of warts elsewhere, and after raising the dose to 7 minims (0.45 gramme) of Fowler's solution, given thrice daily, the growth had entirely disappeared. The age of the patient was about 7 years.

Mr. Ward, in reply, said he would not again be inclined to do laryngectomy for papilloma in children. He thought the child would have died from any operation on the larynx. At the same time he knew now of three cases of curetting and dissection followed by recurrence and closure of the larynx, thus rendering the operation useless. He did not think, however, that children were usually suitable subjects for the operation. He had not seen his procedure described elsewhere.—*British Medical Journal*, May 16, 1896.

ITALY.

Turin Academy of Medicine.

The Etiology and Treatment of Ozæna.—Belfanti and Della Vedova gave the results of their researches on this subject, carried out at the Institute of Serum-therapy, in Milan. They regard the disease as undoubtedly of bacterial origin, and due to a bacillus identical with that of Lœffler in form and characteristics, but differing from it in a great attenuation of virulence, causing only œdemas and moist gangrene at the site of the injections in guinea-pigs. The micro-organism is found in the exudate in ozæna, in the depth and on the surface of the diseased mucous membrane, and gives rise to a chemical change in the secretion and to atrophy of the mucous membrane and the bone.

In view of these facts, the authors decided to employ the antidiphtheritic serum in the treatment of the disease, and they give the details of 32 cases, 16 of which were cured, 7 almost cured, 5 improved, and 4 showing slow improvement. The uncured cases are still under treatment, and the authors look for successful results in these also. The method of treatment consisted in making injections of 10 cubic centimetres ($2\frac{1}{2}$ fluidrachms) of antitoxin every two days, or every day, if possible, until about thirty injections had been given, the number varying according to the age, duration of the disease, and local and general reaction of the remedy. The changes produced were: (1) a turgescence and congestion of the diseased mucous membrane, (2) disappearance of the characteristic odor, (3) appearance of fluid exudate, and (4) disappearance of green crusts. These alterations varied as to the time of their manifestation and their intensity. The complications produced during the treatment were neither severe nor dangerous, though the authors recommend suspending the injections until they disappear.

Bozzolo reported two cases treated by him with the antitoxin; the first a girl, 13 years of age, with chronic ozæna of an exceedingly fetid character. The odor entirely disappeared after the fourth injection, but on suspension of the treatment it returned after some time. Three injections were then made and the odor again disappeared. Multiple subcutaneous hæmorrhages made it necessary to abandon the treatment. Soon after the girl developed measles. At the time of report the condition of the nasal cavities was excellent. The second case was that of a woman of 43 years, in whom the bad smell disappeared after the fifth injection of serum. She was still under treatment at the time of report.

Gradenigo stated that he had treated sixteen cases of ozæna with the serum. In five of these the bacteriological diagnosis had been made by Belfanti. In all there had been an improvement, though the number of injections had not as yet been sufficient to cause complete cure. One case of purulent ozæna had been particularly benefited. He had noted a specific, elective action of the serum upon the diseased mucous membrane.—*La Settimana medica*, April 4, 1896.

LOMBARDY MEDICAL ASSOCIATION.

Serum-therapy in Cancer.—DR. JONA, after a brief survey of the recent literature of the subject, critically analyzed the various attempts to utilize sero-therapy either by inoculating the patient with the toxin of erysipelas or by injecting the blood-serum of animals prophylactically inoculated with liquid drawn from carcinomatous tumors. This latter method, according to the instructions laid down by Dr. Richet and Dr. Héricourt, was that adopted by Dr. Jona, who had under his care six persons suffering from that special form of malignant disease. One of these patients —a woman who for six or seven months had labored under well-defined cancer—was manifestly relieved by the treatment; another—a man afflicted with cancer of the stomach and unable to digest or even tolerate food passed down the œsophagus—had no sooner begun the sero-therapy than he recovered the power of alimentation by the *primæ viæ*, digesting with perceptibly favorable results as many as twelve eggs daily. Two other patients —one suffering from cancer of the tongue and the other from cancer of the rectum—showed distinct improvement after the first injections; but the improvement was not maintained. The fifth and sixth cases, one of cancer of the tongue and the other of the inferior maxilla, remained without response to the treatment.—*Lancet*, May 9, 1896.

UNITED STATES.

ASSOCIATION OF AMERICAN PHYSICIANS, WASHINGTON, D. C.

Certain Effects of Bromo-Toxication.—DR. S. WEIR MITCHELL, of Philadelphia, related a number of observations of the effects of large doses of bromide upon the nervous system. The father of an epileptic girl increased the dose of bromide from 60 grains (4 grammes) a day to 150 grains (10 grammes). She was found with the head dropped forward, in a state of mental hebetude, saliva running from the mouth, eyes open, pupils enlarged, and hard to arouse; the general epileptic convulsions had ceased, but the lesser fits were quadrupled in number. Withdrawal of the bromides restored her to her normal condition, which was usually rather intelligent. A nurse, by mistake, gave two epileptic children nearly 100 grains (6.5 grammes) of lithium bromide a day for mild epilepsy. In a few days both were brought into a condition of extraordinary feebleness of mind and body. Neither of them could walk; the left leg was more affected than the right. They were restored within two or three days after withdrawing the bromide.

Dr. Mitchell related equally striking cases of melancholia, with and without suicidal tendency, produced by large doses of bromides in some form. The enfeebling effect of bromides upon the muscular system and upon the mind, or irritation of the latter, was sometimes seen in alcoholics or those suffering from insomnia who had taken the bromine in the form of bromo-caffeine, bromide of sodium, etc. Habitual drunkards sometimes said they became more drunk on one side than on the other, oftenest on the left. A similar result was observed sometimes from excessive doses of the drug under discussion.

Dr. E. G. Janeway, of New York, had seen three deaths result from excessive doses of bromide. Autopsy revealed no other cause. He knew of two other fatal cases through coroners. The amount used per day in the former cases had been 1 ounce (30 grammes), 6 drachms (23 grammes), and 3 drachms (12 grammes), continued some time. He had seen less serious results in other cases, in alcoholism, in typhoid fever, etc.

Dr. Hobart A. Hare, of Philadelphia, said that the studies of Ringer and some others had shown that potassium was the base of some of our more poisonous salts. He had known citrate of potassium given for several days produce alarming nervous depression in a child. In some of the cases related by the author some other bromide was used than potassium; yet he would suggest that physicians should use the bromide of potassium less than they were accustomed to do, and employ, say, sodium bromide.

Dr. Lyman corroborated the author's observations, and Dr. W. H. Thomson related three cases of temporary mental alienation due to large doses of bromides.

Dr. C. L. Dana had not noticed the difference in the effects on the nervous system between potassium bromide and other bromides suggested by some writers. It was well known that iodide of potassium was often administered in very large daily doses, over 300 grains (20 grammes), without much depression. Small doses of bromide of potassium, etc., often had the reverse effect of depression, causing a feeling of cheer, and it was his custom to begin with only 4 to 6 grains.

Dr. Mitchell said that he had never been able to see more depressing effects from potassium salts than from other bromides.

Idiopathic Osteopsathyrosis in Infancy and Childhood.—Dr. J. P. Crozer Griffith, of Philadelphia, in a paper on this subject, stated that osteopsathyrosis, or fragilitas ossium, is a comparatively rare condition at any time of life or dependent upon any cause. It is far most frequent in advanced years, and is then due to an atrophy of the osseous structure. At other periods of life it may be symptomatic of other affections, such especially as certain nervous diseases, osteomalacia, rickets, etc.

There are still a number of cases remaining which may be called idiopathic, since they can be traced to no recognizable cause and as most of them are not associated with any atrophy or other visible pathological alteration of the bone. Some of these occur in youth and adult life, but the writer confined himself to those developed in early years and reported a case in point, that of a boy who had several fractures, occurring at or soon after birth, and who, up to the age of 2 years, had suffered, in all, seventeen or eighteen fractures. The slightest cause was sufficient to produce them, and it was necessary to keep the child upon a stretcher, so great was the fragility of the bones. The general health of the subject was good, and there was no constitutional affection in him or his parents which accounted for the condition.

The cause is unknown. With regard to pathology and diagnosis, the writer discussed briefly the relation of the disease to rickets, to osteomalacia, and to imperfect osseous development. The latter is especially exemplified in some of the reported instances of multiple intra-uterine fractures. The disease may, and probably does, bear a certain relation to these pathological conditions, but it is distinct from them. In his opinion, it is not at all of a rickety nature, although it may sometimes be combined with rickets.

Dr. Lyman, of Chicago, said that he had once seen a man of 25, who up to that age had sustained thirty-three fractures. There was also a tendency to bending of the bones, shown in the pelvis, tibia, etc. The tibia was translucent to a ray of light. The general health was good. No fractures had occurred for two years, or since the age of 23.

A Method of Curing Tic Douloureux.—Dr. Charles L. Dana, of New York, referred to the rebelliousness of these cases to medicinal and even to surgical treatment. One patient, who had had the Gasserian ganglion removed by a surgeon, suffered not only a recurrence of the pains, but became insane. The method by which he and Dr. Elliot, of New York, had cured seven out of eight cases consisted in hypodermatic injections of very large doses of sulphate of strychnine. Rest abed was enjoined during the treatment, and freedom from care. Strychnine injections were given once a day, beginning with, say, $\frac{1}{30}$ grain (0.002 gramme) and rapidly increased to $\frac{1}{5}$ or $\frac{1}{4}$ grain (0.012 or 0.015 gramme). Patients could not usually take more than $\frac{1}{4}$ grain (0.015 gramme). The large doses had a peculiarly anodyne effect, quieting the patient for hours like morphine. Usually the injections were discontinued after five or six weeks, but might have to be renewed once or twice again. On discontinuing it he gave iodide of potassium, nitroglycerin, or other drugs. In a former paper he had impressed the importance of arterial sclerosis in neuralgic tics. As this treatment had only been begun two years ago, he was hardly justified in speaking of the result as a cure, yet it had been in such contrast with that obtained by other methods that he wished to emphasize its value.

A Case of Œsophageal Hæmorrhage with Cirrhosis of the Liver.—Dr. G. M. Garland, of Boston, related a case in a well-built man. The first hæmorrhage was in 1888; recurrences followed up to the fatal one in 1895. The loss of blood by vomiting and passage with the stools was great, amounting at times to more than two quarts. Toward the end particularly the blood came from the mouth almost constantly, without the act of vomiting. When he first saw the man, in 1889, he and other physicians diagnosticated ulcer of the stomach, and it was not until later that cirrhosis of the liver was discovered. At autopsy no source of hæmorrhage was discovered except from the much-dilated and very thin-walled veins at the lower end of the œsophagus. The histories of three other cases had been furnished him by Dr. Osler and physicians in Boston. The dilatation of the œsophageal veins leading up to hæmorrhage depended upon obstruction to the portal circulation from cirrhosis of the liver.

Dr. Graham, of Toronto, mentioned a case reported by McKenzie, of fatal œsophageal hæmorrhage from varicose veins in a boy of 17 years whose liver was healthy.

Dr. S. Weir Mitchell had also seen a case of fatal œsophageal hæmorrhage in a child, in which autopsy revealed nothing but marked varicosity of veins in the lower part of œsophagus. The attending doctor had called the condition œsophageal piles,—which graphically described the appearance.

Dr. Jacobi remarked that a close study of the structural changes in the œsophageal veins was desirable in order to explain why the hæmorrhage should have been from these instead of from the more usual situation in the veins of the stomach, etc., in connection with cirrhosis of the liver. It was not improbable that those veins were atheromatous, for, while atheroma was much more common in the arteries, it did sometimes occur in veins.—*Medical Record*, May 9, 1896.

American Medical Association, Atlanta, Ga.

The Importance of Fevers in the South.—Dr. William Osler, of Baltimore, in the address on medicine, referred to the fact that humanity has but three great enemies,—fever, famine, and war,—and mentioned the interesting circumstances that three of the greatest benefits conferred on mankind have been in connection with fevers,—the introduction of cinchona, the discovery of vaccination, and the announcement of the principle of asepsis. He then discussed in a brief manner the way in which the continued fevers had been differentiated during the present century, and paid a tribute to the part which had been played in this work by the American students of Louis, the great French physician. The prevalence of typhoid fever in the United States was such as to make it to-day the fever of the country. He referred to its apparent increase in the smaller towns and in the country-districts, and suggested that the profession in these parts should give very much more attention to local health matters. In the Southern States for many years typhoid fever was not supposed to be very prevalent, but of late physicians had begun to recognize that the increase was wide-spread.

He spoke of the necessity of knowing fully the complex and varied symptomatology of the disease, and of the unfailing accuracy with which it could now be differentiated from malaria. He then spoke of the contrast between the treatment of typhoid fever at the beginning and at the close of the century, and criticised strongly the so-called abortive and antiseptic plan of treatment which had been advocated in the *Journal of the American Medical Association*. He discussed the importance of the study of malaria in the South from the new stand-point of Laveran's researches, and urged that the younger physicians should equip themselves thoroughly for this work, referring to a number of problems which yet awaited solution.

Lastly, he took up the question of the existence of a third type of fever in the South independent of both typhoid fever and of malaria. He held that the evidence was not conclusive as to its existence. On the contrary, the trend of opinion seemed strongly in favor of the view that it was typhoid fever, although he confessed that further work was needed before the problem could be declared settled.

"Scientific Researches Relating to the Specific Infectious Agent of Small-pox and the Production of Artificial Immunity from this Disease" was the title of an address by George M. Sternberg, Surgeon-General of the United States Army.

The experimental evidence relating to the nature of the specific infectious agent of vaccine and of variola was reviewed; also that relating to the genetic relation of cow-pox, horse-pox, and small-pox; and that relating to the production of artificial immunity by subcutaneous inoculations with vaccine-lymph and by subcutaneous or intra-venous injections of blood-serum from immune animals.

The following conclusions were presented:—

1. Small-pox, cow-pox, and horse-pox are genetically related, being different manifestations of the same infectious disease in different genera of animals.

2. The specific infectious agent of variola and of vaccinia has not been demonstrated. The extended experimental investigations which have been made indicate that it does not belong to the class of micro-organisms known as bacteria.

3. Various bacteria are commonly found in the lymph from vaccine-vesicles, obtained either from bovine animals or from man. Among these are the well-known pus-cocci, and these micrococci are probably largely responsible for the erysipelatous inflammation and other unpleasant complications which frequently result from vaccination with such lymph.

4. Lymph preserved in glycerin after a time becomes sterile, so far as the presence of bacteria is concerned, without losing its specific virulence.

5. Immunity may be induced by subcutaneous inoculation of vaccine-virus without the development of a vaccine-vesicle; and it is probable that the subcutaneous injection of lymph preserved in glycerin would give protection without any of the septic complications so common as a result of vaccination by the usual method.

6. The blood-serum of immune animals contains a substance in solution which destroys the specific virulence of vaccine-virus when brought in contact with it.

7. This substance is not present in sufficient amount to make the blood-serum of immune animals available for the production of immunity in man (or for the treatment of variola). But it may perhaps be obtained in a concentrated form by chemical methods, and in that case would be likely to prove useful, and possibly specific, as a therapeutic agent in this disease.

8. The immunity resulting from the subcutaneous injection of vaccine-lymph, like that resulting from vaccination in the usual manner, is gradually developed and is not complete until the eighth day, depending, no doubt

upon a multiplication of the infectious agent in the body of the susceptible animal. On the other hand, the immunity resulting from the transfusion of a large amount of blood-serum from an immune animal to a susceptible animal is an immediate result of such transfusion.—*Medical Record*, May 9, 1896.

Chicago Ophthalmological and Otological Society.

The Efficiency of Salicylates in Therapeutic Practice.—Dr. Gradle stated that salicylates have been used in ophthalmic practice and recommended in the books for nearly twenty years, but that very few authors state definitely what and how much can be expected of the drug in different diseases. In the mild forms of episcleritis the salicylate of sodium has a prompt effect in checking the disease. In corneal diseases he has found it useless except in one form, keratitis, presumably dependent upon rheumatism or gout. This keratitis is characterized by deep striations or discrete spots of infiltration in the cornea, with a more or less diffuse haze. It has an indefinite course, but yields within a few days to the action of salicylate of sodium. In iritis he never observed a specific effect. In eight instances patients with rheumatic manifestations and iritis were benefited as far as the rheumatism was concerned, but the salicylic acid did not prevent the iritis from taking its usual course. It will often mitigate the pain and in some instances apparently shorten the disease, but this effect cannot be predicted. It requires doses of at least 1 gramme (15½ grains), repeated four or six times a day, and more if the patient can stand it, in order to obtain the benefit of salicylates. It has no effect upon an acute cyclitis, but when the disease has passed the acute stage and then has an indefinite duration, or exacerbations and relapses, a very prompt checking effect was found in the majority of instances. This is true of cyclitis following retinal detachment, cyclitis of traumatic origin, and, in one instance, of a sympathetic form of the disease. Sometimes a marked benefit was found in twenty-four to forty eight hours. In no other disease of the eye could any decisive results be obtained by the use of salicylate of sodium.

Dr. Holmes had used salicylates only for the relief of pain. For this purpose he had found them of great help, but had not had very satisfactory results from their use as a specific.

Dr. Colburn had used salicylates at times, but had found that antipyrin and similar analgesics accomplish the same results, and, as they were less irritating to the patient's stomach, he considers them better. He used all these drugs for the relief of pain only, and not as specifics.

Dr. Hotz had first used the salicylates systematically in 1878 and reported his results in the *Chicago Medical Journal and Examiner* in 1879, about the time that Chisholm made his report. He disagreed with the former speakers in regard to the value of the salicylates as a specific. In cases of rheumatic iritis the relief from pain and other symptoms was very marked, following the administration of the salicylates in large doses. Referring to the benefits Dr. Gradle had derived from them in cases of cyclitis, but not in iritis, he said that all severe cases of iritis were complicated with cyclitis, and that Dr. Gradle's experience was only proof of the value of salicylates in iritis. He generally gave the salicylate of sodium in 5-grain (0.32 gramme) doses, repeated at very short intervals, instead of 15-grain (1 gramme) doses every two hours or so.

Dr. Coleman's experience corresponded with Dr. Gradle's as far as iritis was concerned. He had found the drug of but little value, although he had used 15-grain (1 gramme) doses very persistently. He now uses small doses of calomel, until relief is experienced. A recent case of herpes zoster ophthalmicus, which had suffered greatly from severe pain for ten days, was relieved by salicylate of soda, when all other drugs had failed except morphine.

Dr. Hale had found the oil of wintergreen just as efficacious, while it did not disturb the patient's stomach nearly as much as did the salicylate of soda.

Dr. Pierce also spoke of the use of wintergreen as satisfactory.

Dr. Wurdemann had but little use for the salicylates. In iritis he had always used mercury with satisfactory results.

Dr. Hawley preferred salicin, 20 grains (1.30 grammes) every hour, and sometimes as high as 30 grains (2 grammes) every hour. It is less irritating, and no unpleasant effects follow the use of large doses.

Dr. Oaks used salicylic acid prepared from the oil of wintergreen, and not the one used synthetically. The results are better and the preparation less irritating than the synthetic form.

Dr. Gradle preferred the salicylate of soda in the solid form; in 5-grain (0.32 gramme) tablets it was less irritating than in solution. It is absolutely useless to use doses smaller than 15 grains (1 gramme), repeated every two or three hours.—*Journal of American Medical Association*, March 28, 1896.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÄDIATRIK, OBSTETRIK, GYNÄKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter etc., der adkomme i Danmark bedes sendt til

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Norrevoldgade, 13,
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Infectious Icterus in Children.—Ulrik (*Ugeskrift for Läger*, p. 265, 1896) relates three cases of contagious icterus in children, 7, 8, and 10 years of age, all of whom presented the same symptoms,—anorexia, fever, and icterus,—which set in after the decline of the fever and which continued only for a few days. Two of the children belonged to the same class in school and the third came daily in contact with the first child; none of the grown-up members of the families were taken ill. Small epidemics of contagious icterus are not rare in Denmark. Ordinarily the disease is not severe, but it may be so, and has caused sudden death.

Mortality from Phthisis in Denmark.—LÖREN HANSEN (*Ugeskrift for Läger*, p. 121, 1896) finds that the mortality from phthisis pulmonalis in Copenhagen has declined very markedly during the last fifteen years, as well absolutely as in proportion to all deaths. While in the period from 1860 to 1879 that proportion was 13.8 per cent. for men and 12.3 per cent. for women, in the years 1890 to 1894 it was 11 per cent. for men and 8.7 per cent. for women.

Comparative Value of Remedies for Uric Acid.—F. LEVISON (*Ugeskrift for Läger*, p. 1, 1896) has examined the new remedies recommended as solvents for uric acid, not only for concretions in the kidneys, but for the form of uratic deposits in gout. Evidence from literature, as well as his own experience, leads him to the conclusion that neither piperazine, lycetol, nor lysidin had any special remedial property in this affection. They combine readily enough with uric acid to form soluble salts, but when given *per os* and excreted with the urine they lose that property completely or in greater part. Another new remedy, urocedin,—recommended by Mendelsohn,—is a combination of citrate of sodium and sulphate of sodium with small quantities of citrate of lithium and chloride of sodium, and is not superior to the citrate of sodium so long in use.

More remarkable results are obtained from urotropin, introduced by Nicolati. This remedy can be taken in a dose of 1 to 2 grammes (15½ to 31 grains) a day. It is rapidly excreted by the kidneys and can be demonstrated by bromine-water, which gives a yellow, crystalline sediment.

Levison found that the urine of a person who had taken 1.5 grammes (24 grains) of urotropin was able to dissolve small quantities of uric acid by passing through a filter covered with 0.50 gramme (7¾ grains) of uric acid; when the uric acid was digested for twenty-four hours with the urine containing urotropin, as much as 16 to 18 per cent. of it was dissolved. Concretions of uric acid treated with this urine were somewhat diminished in weight, and their surface became uneven and grayish instead of yellow. Still another property is conveyed to the urine by urotropin,—it is rendered bactericidal and aseptic. The urine could be held for many days in the thermostat at a temperature of 37° C. (98.6° F.) without becoming foul, even when different cultures of bacteria were added to it, while samples of urine without urotropin fermented and putrefied in a very short time. Urotropin seems thus to be indicated in suppurative diseases of the kidneys and bladder; it must, however, be observed that in one experiment the urine containing urotropin began after some days to precipitate a crystalline sediment of phosphate of lime; if such a precipitate took place in the living body it would, of course, be a serious inconvenience in the use of the remedy.

Tuberculosis in Cattle.—BANG (*Bibliothek for Läger*, p. 31, 1896), professor at the veterinary school of Copenhagen, has commenced a regular campaign against tuberculosis in cattle, which disease in Denmark, as in most other countries, is becoming a serious danger. Bang expresses the conviction that all cases of tuberculosis are caused by infection, and that predisposition, overexertion, and all other reasons invoked to explain the frequency of the disease are only of secondary importance; the infection is virtually limited to the stables and is in most cases propagated by the milk. Tuberculosis may be directly inherited, but only rarely and when the parents are very strongly affected. By injection of tuberculin (Koch) the veterinary surgeon has now a reliable, although not an infallible, means of diagnosing tuberculosis, even in its early stages. Errors in diagnosis may be calculated as about 5 per cent. By this means it is possible to combat the disease.

In April, 1892, Bang commenced experiments at a large farm in Seeland, Thurebylille, demonstrating by the injections that of 208 animals 131 were infected, only 77 being healthy; of the milking-cows about 80 per cent. were infected. The stable was thoroughly cleansed and disinfected and divided into two parts by a wooden partition reaching from the floor to the roof. All calves that had shown the reaction were killed. One part of the stable was set apart for the healthy and another for the diseased cows, and all communication between the two was strictly prohibited; even the workmen were divided into two classes,—one for the healthy and one for the infected cattle.

All calves delivered after the beginning of the experiment were at once brought to the healthy portion of the stable and were fed with boiled milk, except on the first day of life, when it was found necessary to give them the first milk of the cow heated to a temperature of 65° C. (149° F.), by which temperature the virulence of the bacilli is weakened, although not destroyed. Twice a year all the animals of the healthy portion were subjected to an injection of tuberculin in order to ascertain their condition. While this experiment in the first year resulted in the detection of several new infections, in the last year very few new cases have been found.

After the lapse of three and one-half years the result of the whole procedure was, in October, 1895, found to be that the stock, which originally consisted of 131 infected and 77 healthy animals, now numbered 69 infected and 132 healthy animals. These results had been reached only by breeding the calves born on the farm, without buying a single cow.

The Danish government has now adopted this manner of combating tuberculosis in cattle, and the experiments are continued on a large scale at public cost.

Holland.

DR. A. MIJNLIEFF,
REDACTEUR CORRESPONDENT FÜR
GEBURTSHÜLFE UND
PUERPERAL KRANKHEITEN.

Alle Bücher, Thesen, Separat ab drücke, etc., über obengenannte Gegenstände in hollandische Sprache erscheinend, solten Herrn

DR. MIJNLIEFF,
Breukelen,
Holland.
zugesandt werden.

Acute Œdema of the Cervix in Pregnancy.—GEYL (*Geneeskundige Bladen*, vol. ii, No. 4) describes a case of peculiar rarity in obstetrical practice, only seven similar cases being known in literature. An acute œdematous swelling developed in the neck of the uterus, which, suddenly slipping out to the vulva, caused violent tenesmus in urinating and pains in the inguinal and vulvar region. There was an excessive sero-mucous or muco-sanguinolent secretion. According to the author, rest in bed ordinarily causes the swelling to disappear spontaneously, and with it the prolapse. Active therapeutic measures are not usually necessary. The affection may be met with in pregnancy, delivery, or the puerperium.

This acute œdema ought to be strictly separated from the œdema found in chronic prolapse or in elongation of the gravid cervix. In the latter case it may be necessary to make incisions at the birth of the child, as the neck is very rigid, while in the acute œdema nature comes to the aid of the patient.

The etiology is only hypothetical. The author believes that pressure of the body of the uterus on its neck may be responsible for the condition, while Hamburger's bacterium lymphagogon has also been regarded as the cause.

Uterine Carcinoma in Pregnancy.—G. H. VAN DER MEY, the deeply regretted professor of gynæcology and zealous member of the ANNUAL'S corresponding staff, has left as his last work a complete study of the subject of uterine cancer as regards this subject (*Geneeskundige Bladen*, vol. ii, No. 12), its influence on conception, pregnancy, and delivery, and inversely the effect of gravidity on cancer. He also deals with the question of therapy, after carefully reviewing its literature.

In cases in which the disease is confined to the uterine tissue and where the parametrium is not infiltrated he advocates total extirpation. In one case, in the fifth month of pregnancy, the author performed vaginal hysterectomy with good results. If the volume of the uterus is too great, he advises previous removal of the liquor amnii. Where total extirpation is impracticable, all efforts should be made to save the life of the child. If the resistance of degenerated tissue be so great that the fœtus cannot pass the birth-channel, Cæsarian section is indicated. Perforation of the living child he regards as not allowable in these cases. Whether the Cæsarian section is a conservative one or a Porro operation must depend on the individual case. In some cases it may be succeeded by Freund's total extirpation of the uterus.

Norway.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÄDIATRIK, OBSTETRIK, GYNÄKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

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DR. LEVISON,
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Noma.—LYDER NICOLAYSEN (*Norsk Magazin for Lägevidenskaben*, p. 137, 1896) made a bacteriological examination in two cases of this disease. In the first case he found bacilli and cocci, the former being very numerous in the necrosed portions and penetrating but little into the neighboring parts, while the cocci had penetrated deeply into the lymphatics of the surrounding healthy parts. Cultures yielded a liquefying staphylococcus and but a single bacillus, staining by Gram's method and resembling the bacillus of diphtheria. Neither of these organisms proved pathogenic to guinea-pigs. In the second case the author found a bacillus exactly resembling that in the first case. According to him, this bacillus differs markedly from the bacillus of noma as described by Schimmelbusch.

Treatment of Prematurely Born Infants.—JOHANNESEN (*Norsk Magazin for Lägevidenskaben*, p. 289, 1896) has in the course of two years used the Adile-Martin incubator in ten cases. Six of these had been born before term, and the temperature was as low as 35° C. (95° F.) or even 34.5° C. (94.1° F.). The temperature of the incubator was kept at 30° C. (86° F.), and the infants were fed with a mixture of milk and a solution of condensed milk 6 per cent., sterilized in Soxhlet's apparatus. The infants were kept in the incubator from eight to one hundred and ten days. Although the immediate result of the treatment was fairly good, the temperature rising after a few days and the body-weight increasing considerably, the ultimate result was not very encouraging. Some of the children died of hereditary syphilis and others soon presented symptoms of digestive disorders and fell into a condition of athrepsia. The author is of the opinion that good effects cannot be obtained from the incubator unless its use is combined with nursing at the mother's breast.

Poland.

DR. J. DRZEWIECKI,

Redaktor Korespondent z działu polskiej literatury tyczącej się: Medycyny ogólnej i lecznictwa; pediatryi; akuszerzyi; ginekologii; laryngologii; otologii; hygieny; demografii; medycyny sądowej; histologii; patologii; bakteryjologii; anatomii; fizjologii.

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w języku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

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Warszawa,
Królestwo Polskie.

The Value of Atropinization of the Eye before Extraction of Cataract.—Two years ago, relying upon his results in seven cases, DR. MUTTERMILCH expressed the opinion that complete atropinization of the eye before extraction of cataract is extremely favorable to the successful issue of the operation. He now confirms this opinion, having already tried the method in one hundred and seventy cases. The use of atropine in the eye before operation is important in the diagnosis, as with a dilated pupil it is much easier to ascertain the kind of cataract. It is much easier to introduce the instruments, which is especially important in tearing the capsule of cataract by the cystotome, and in the use of the pincette. The introduction of the pincette with a narrow pupil, if iridectomy is not performed, is in some cases very difficult, and sometimes not without danger, as the iris may be caught. Atropinization of the eye prevents adhesions of the iris with the remains of the cataract and facilitates their absorption. As the action of atropine lasts some days, a bandage is not necessary for the first few days. The author found it necessary to examine the eyes only four days after operation, unless the patients complain. Atropinization prevents inflammatory processes and prolapsus of the iris is much more rare. Out of his one hundred and seventy cases it occurred only in seven,—*i.e.*, 4 per cent., while before, when he did not use atropine, the percentage of prolapsus was fifteen. He has never employed iridectomy since he used atropine, and considers that atropinization of the eye should be made before every extraction of cataract.—*Gazeta Lekarska*, No. 9, 1896.

Antidiphtheritic Serum.—DR. STAPA presented to the Krakow Medical Society an account of the treatment of diphtheria with serum in the Krakow Hospital for Children. In 1895 there were 258 children treated. Different serums were used: Behring's, Roux's, Aronson's, Paltauf's, and Bujwid's. Of the different syringes the most suitable was Aronson's, this being the most easily disinfected. There were 189 children below 3 years, the remainder being older. Croupous laryngitis was observed 165 times. The mortality was 22 per cent. Fifty-eight times after injection of the serum an eruption was observed, lasting two to sixteen days and similar to scarlet rash. Some invoices of Bujwid's and Paltauf's serum always occasioned rash. As regards the appearance of albumin in the urine, the serum had no influence. In seven cases relapse ensued after ten to twenty days, and in three after two to three months.—*Nowiny Lekarskie*, February, 1896.

Russia.

DR. J. DRZEWIECKI,

РЕДАКТОР-КОРРЕСПОНДЕНТ из области русской литературы, касающейся: Общей медицины и терапiи, педiатрiи, акушерства, гинекологiи, ларингологiи, отологiи, гигiены, демографiи, судебной медицины, гистологiи, бактерiологiи, анатомiи и физiологiи.

Всѣ перiодическiя, медицинскiя изданiя, сочиненiя, стат'и, монографiи и т д., изданныя на русском языкѣ и касающiяся вышепоименованных предметовъ должны быт' адресованы на имя

ДРА ДРЖЕВЕЦКАГО.

87 Краковское Предмѣст'е,
Варшава.

Rachitis and its Relation to Dampness.—HAGEN-TORN, in a study of this subject, comes to the following conclusions: 1. Rachitis is an endemic disease, depending on the degree of the yearly dampness in the respective country. By this is also explained the oscillation of its frequency in connection with the season (increase in winter). 2. Disorders of digestion are most frequently the consequence of the disease. 3. Rachitis is accompanied by changes in all the organs. 4. Disorders in nutrition of the organism and in the development of bones are the consequences of disorders of general metabolism. 5. The disorders of metabolism, however, are occasioned by the retention of the dampness in the tissues of the body. 6. In localities where the yearly average dampness is higher than 80° F. rachitis is, as the author expresses it, a physiological condition. In localities between 80° and 70° F. of dampness it develops only in specially unfavorable conditions of lodging and care of children. In localities, however, with dampness below 70° F. rachitis does not occur.—*Vratch*, No. 17, 1896.

Suture of Wounded Blood-vessels.—Two cases of this kind are recorded by DR. SABANYEFF, of Odessa. In the first the suture was applied to the femoral vein, wounded during excision of the inguinal glands, and in the second to the femoral artery. In the latter case the patient died from the original disease and the sutured artery was microscopically examined by Dr. Padalka, who found that the healing of the wound of the artery took place from outward to inward,—*i.e.*, that above all intima of the vessel healed, and parts approached by the suture healed sooner than those removed. In the same article the author studies the question of cardiac suture. He made a series of experiments upon rabbits and arrived at the same conclusions as Block and Vecchio.—*Hirurguitchesky Archiv*, 1895.

Treatment of Eczema by Steam.—A. Liberson, in two cases, observed that a current of steam of 40° to 50° C. (104° to 122° F.) directed to the affected parts of the skin in eczema removes crusts and scales, occasions increased scaling of the epidermis, favors the absorption of superficial and deeper infiltrations of the skin, diminishes or even entirely stops formation of pus on the surfaces deprived of epidermis, and at the same time produces increased regeneration of tissues where, on account of chronic processes, the conditions for healing are very unfavorable. The apparatus which the author uses consists of a thick copper cylinder containing two or three glasses, the bottom one being heated with an alcohol-lamp. On the top are two openings,—one for pouring in water (closed by means of a screw) and the other for a bent tube. According to the sensibility of the skin, the tube is kept three to five inches from it. The *séance* lasts fifteen to thirty minutes. Instead of pure steam, steam with addition of some medicines may also be employed.—*South Russian Medical Gazette*, Nos. 51 and 52, 1895.

Primary Poliomyositis.—Very few cases of primary affection of the muscles have been described. Dr. Korniloff had occasion to observe clinically and afterward to make minute microscopical examination of this rare disease in a man of 31 years, in whom subacute parenchymatous nephritis developed with œdema and large quantities of albumin; in consequence symptoms of affection of pleura and pericardium appeared. Shortly after the symptoms of Bright's disease commenced distinctly to diminish. A month after his entering the hospital, and two months from the beginning of the disease, the temperature rose and violent pain in the abdomen set in, and at the same time œdema of the inferior extremities began again to augment; ten days after œdema appeared also in the upper extremities. The temperature remained augmented to 38.6° C. (101.5° F.) and the patient became feebler and feebler. Three weeks after this aggravation the quantity of urine rose to 5700 cubic centimetres (183 ounces), while before it was only 2000 cubic centimetres (48 ounces); at the same time great weakness in feet and hands was remarked, and after two days complete paralysis of all the extremities. There was no pain, but pressure on the muscles was very painful. Feeling was entirely preserved, as well as the function of all organs of the pelvis. All muscles did not react to faradic electricity, and some only slightly reacted to the galvanic current (with inversion of formula). In the last day of life atrophy set in and was more marked upon the muscles near the larger joints. Sensibility was never affected. Post-mortem examination showed chronic parenchymatous nephritis and pericarditis; there was no changes in the central peripheral nervous system on macroscopical as well as microscopical examination. Only the muscles presented enormous changes in the form of myositis, affecting the parenchyma as well as the interstitial tissue. The changes in the parenchyma consisted principally of vacuolation of fibres and atrophy; the interstitial cells were imbibed and proliferated. The large muscles were more affected than the small. As in his case there was no affection of the skin, the author considers that this disease should be properly called not dermatomyositis, but polymyositis primaria.—*Vratch*, No. 8, 1896.

The Treatment of Lunatics in Bed.—Dr. Timofeyeff, in the course of some remarks on this subject, based on observations at the Hospice of Alexander III in St. Petersburg, states that every new patient is put to bed, where he remains a certain time, and afterward transferred for further treatment, according to his condition, to another ward. Patients with acute disease or requiring special watching remain in bed in the observation ward till indications appear to transfer them to another ward. To the observation ward for treatment in bed are temporarily transferred patients from other wards whose state requires quiet and strict watching. In the wards for quiet lunatics patients are put to bed at the least burst of excitement, thus avoiding removing them to wards for furious patients or for observation. The patients kept in bed are given as much as possible some suitable occupation. All acute cases, especially with excitement or bad nutrition, are kept in bed till their weight commences to rise and their psychical condition to improve. No compulsory means for retaining the patients in bed are necessary in the majority of cases; only exceptionally is it necessary to apply force. The reason why lunatics lie quietly in bed must probably be looked for in the impressions of the ward itself, where all the other patients are lying in bed. The advantage of such treatment is undoubted. Acute psychoses end sooner and favorably. Exhausted patients improve considerably; the hospital, and especially the wards for maniacs, makes a more agreeable impression; medical observation and watching is much easier and does not require large attendance; isolation of the patients is very seldom necessary. During the last three years no case of isolation occurred in the Hospice of Alexander III.—*Obozrenie psychiatry, nevrologi*, etc., January, 1896.

Clinical Notes and Lectures.

A Sign of Pleural Effusion.—Although, as a rule, the signs given by a collection of fluid in the pleura, whether serous or purulent, are definite enough to allow of an easy diagnosis, cases sometimes occur where the presence of lymph adherent to the visceral or parietal pleura, or thickening of the pleura itself, gives signs which so closely resemble them that the differential diagnosis becomes a matter of some difficulty. In such cases the presence or absence of the following physical sign has been found useful by T. H. Kellock, of London. The patient should be standing, or in the sitting position, with the head and neck inclined forward so as to render the skin and muscles of the back somewhat tense. The observer stands on the left side of the patient and, placing the left hand flat and fairly firmly on the lower part of the thoracic wall just below the nipple, percusses sharply either with a finger of the right hand or with a pleximeter on the ribs of the same side, striking them just posterior to the angles, when, if no fluid be present, a very slight vibration of the rib which is struck posteriorly is felt by the left hand in front; but if there be fluid in the pleura the vibration of the rib is much greater, and if the quantity of fluid be at all considerable the difference between the sensations experienced by the left hand when examining the sound and affected sides is most marked. This description as to position of hands, etc., applies, of course, to cases where the effusion is of some quantity, but by changing the position of the left hand and the spot where the rib is percussed posteriorly the author has been able to elicit and demonstrate this sign where the quantity of fluid was small; it requires a little practice, but when once the sensation is thoroughly appreciated it is easily recognized again. In cases of bilateral effusion there is not, of course, the advantage of a sound side for comparison, but even in these experience may tell the physician whether or not the vibration obtained is greater than it should be. His own experience has been entirely confined to children, whose chest-walls are generally lightly covered and therefore favorable for the manifestation of this sign.—*Lancet*, March 28, 1896.

Occlusion of the Posterior Nares.—In an article on true and false occlusion of the posterior orifices of the nasal fossæ, E. BAUMGARTEN states (*Monatsch. f. Ohrenheilkunde*, No. 1, 1896) that forty-one such cases are recorded in literature. In two-thirds of these the occlusion was bony, in the rest membranous. He gives the name of true occlusion to cases in which the total or partial septum formed by bony or membranous tissue is on the same plane as the choanæ. He reports a case which differs from those already recorded only in the fact that the facial muscles on the affected side were paretic and less developed than those on the other side; so that the face was asymmetrical. False occlusion is always membranous and affects only the upper part of the fossa. The author has recently observed two such cases, one in a woman, 40 years old, who had suffered from nasal obstruction and hoarseness for some years. Posterior rhinoscopy, which was difficult, showed a grayish-red membrane covering the choanæ, inserted on the external border of each in the upper half, and descending obliquely backward into the vault of the palate, which it drew upward. In the upper part of this diaphragm there was an orifice two or three millimetres in diameter.

In the second case the obliteration of the choanæ was not so extensive, there being rather a septum in the naso-pharynx. The patient was a woman, 30 years old, who had complained for ten months of pain and dryness of the throat. Only the posterior half of the vault was visible by posterior rhinoscopy. Both Eustachian orifices and the anterior half of the vault were hidden by a grayish membrane, which moved backward and forward in respiration and which descended obliquely and backward toward the adherent edge of the vault. It thus divided the naso-pharynx vertically into two spaces, the anterior being smaller than the posterior. In the middle of the membrane was an opening four millimetres long and three millimetres wide.

According to the author, the etiology of the condition is obscure, though in the first case he thinks it was possibly a variety of scleroma of the upper respiratory tract, since laryngeal lesions resembling that affection were also present.

Diagnosis of Diabetes by Examination of the Blood.—Dr. Bremer describes a new method of staining red blood-corpuscles by which diabetic blood may be distinguished from non-diabetic blood. A cover-glass preparation of blood is made in the usual mnnner, and a thin, even film obtained. For comparison a similar preparation of normal blood is made. Both are placed in a wide-mouthed bottle or glass, containing equal parts of alcohol and ether (10 grammes—2½ fluidrachms—of each). This vessel is then placed in hot water, and the ether-alcohol allowed to boil for four minutes. The cover-glasses are then stained in a solution prepared in the following manner: Saturated watery solutions of eosin and methylene-blue are mixed in equal parts. A precipitate forms; this is filtered off, washed, and dried. It is then reduced to a powder, and $\frac{1}{24}$ part of eosin and $\frac{1}{6}$ of methylene-blue are added. From 0.025 to 0.05 gramme ($\frac{2}{5}$ to $\frac{7}{8}$ grain) of this mixture is dissolved in 10 grammes (2½ fluidrachms) of a 33-per-cent. solution of alcohol. This staining fluid does not keep well, and must be freshly prepared shortly before the cover-glasses are stained. After remaining in the above fluid for four minutes the cover-glasses are washed in water. The film of diabetic or glycosuric blood is stained sap or bluish green, the non-diabetic blood reddish violet. Under the microscope the red corpuscles of diabetic or glycosuric blood are stained green, while those of non-diabetic blood are stained purple or madder color. Dr. Bremer found this reaction in fifty cases of diabetes mellitus or glycosuria, and believes that in these diseases a diagnosis can be made by examination of a drop of blood. In a postscript he adds that in one case recently examined he has obtained negative results.—*New York Medical Journal*, March 7, 1896.

Tuberculous Meningitis Ending in Recovery.—A case of tuberculous meningitis followed by recovery has been observed by H. A. Janssen (*Nederl. Tydsch. v. Geneeskunde*, February 29, 1896). The patient, aged 19 years, entered the hospital May, 1892, and soon presented symptoms of tuberculous meningitis,—cephalalgia, vomiting, high temperature, slow pulse (52 per minute), irregular respiration, convergent strabismus, dilated pupils, insensibility of the cornea, muco-purulent conjunctivitis; muscular contractions in the nape of the neck, the hands, and the left leg; increased cutaneous sensibility, mild delirium, involuntary passage of fæcal matter and urine, etc.

Sixteen days afterward there was observed a slight amelioration in the condition of the patient; then little by little the symptoms improved, and in the following July he left the hospital entirely restored. The recovery, however, was of short duration; in fact, the man often returned to the hospital, sometimes for laryngitis, sometimes for bronchitis, and finally died of phthisis in August, 1895, without having presented a recurrence of the cerebral symptoms.

At the autopsy the lesions of tuberculous meningitis were found in the convexity and encephalic base. There was a thickening of the pia mater, caused by a new formation of adherent conjunctive tissue in the cerebral substance, in which numerous caseous and fibrous tubercles were disseminated.

M. Janssen thinks that the large doses of iodide of potassium administered to the patient played a certain rôle in the cure of the meningitis. The quantity of iodide of potassium taken varied from 8 to 40 grammes (2 to 10 drachms) a day, and while the meningitic symptoms lasted the patient took, in all, 950 grammes (31 ounces) without appreciable inconvenience. In analogous cases, therefore, large doses of the iodide appear to be indicated.

Congenital Dislocation of Both Lenses.—DR. THOMAS P. C. BARNARD, of North Tonawanda, New York, sends details of the following case: R. B., male, aged 9 years, consulted him, November 28, 1895, stating that vision had always been defective. His family history was good, and subsequent examination of the eyes of the whole family showed all of them to be normal except one aunt, who had H. of +S. 1 D. in both eyes. The boy's vision was: O. D., $\frac{5}{60}$; O. S., $\frac{4}{60}$. The ophthalmoscope showed O. D. lens dislocated directly upward, lower margin being at centre of pupil, disc plainly visible through and below lens; O. S. lens dislocated up and out, but lower margin at centre of pupil; the disc, as in O. D., visible through and under lens.

A Sign of Hereditary Tuberculosis.—M. VICTOR HANOT, from three cases observed by him, believes that stenosis of the pulmonary artery may be a manifestation of pulmonary tuberculosis. He asks whether stricture of the pulmonary artery might not be similar to the congenital aortic stenosis of chlorosis and an heteromorphous manifestation of tuberculosis. It would in that case not be presumptive of phthisis, but of immunity against phthisis.—*Gaz. Hebd. de Méd. et de Chir.*, March 19, 1896.

Recent Suggestions in Therapeutics.

Eucasin.—This is a fine, white powder soluble in warm water, and which is prepared by passing *ammonia-gas* over *casein.* From a number of experiments on animals SALKOWSKI finds that the nutritive value of *eucasin* may be compared to that of *somatose.* The defective absorption of the latter and its liability to induce diarrhœal stools limits its value as an effective nutritive agent. After a loss of weight had been induced in a dog by feeding it on *somatose*, *eucasin* was given by Salkowski, and speedy recovery of weight followed. He concludes that *eucasin* is an albuminous preparation well worthy of further trial for feeding purposes. It can be mixed with carbohydrate soups, broth, cacao, and chocolate. Wine and beer are not suitable, since *eucasin* is not very soluble in them. (*Deut. med. Woch.*, April 9, 1896.)

Hæmorrhoidal Flux.—If the hæmorrhage occur daily, is considerable, and the patient weak and nervous, it should at once be arrested. The writer has generally succeeded in suppressing the hæmorrhage in these cases and restoring the patient's health by strictly observing the following course: To anæmic patients of a nervous and serious temperament he has given the following tonic and anodyne pills: ℞ *Sulph. ferri*, 1 drachm (4 grammes); *ext. belladonnæ*, 6 grains (0.39 gramme); *syr. simplicis*, q. s. M. Fiat massa in pilulas xxiv dividenda. One pill morning, noon, and night. Or, to fulfill the same indication, the following solution has been given to very weak, nervous, and anæmic patients with the immoderate hæmorrhoidal flux: ℞ *Ferri citratis*, 4 drachms (16 grammes); *sulph. quininæ*, 1 drachm (4 grammes); *acidi citrici*, 30 grains (2 grammes); *aq. destillatæ*, 1½ fluidounces (46.5 grammes). Fiat solutio. From 20 to 30 drops of the solution should be taken three times daily in a wineglassful of the cold infusion of *wild-cherry bark* (*Prunus Virginiana*); at the same time the infusion may be drank freely through the day.

In addition to these it is highly important and necessary, in order to arrest the hæmorrhage, to inject into the rectum half a pint of cold water just before each evacuation of the bowels, and soon after the evacuation 2 or 3 ounces (62 or 93 cubic centimetres) of *lime-water* (liquor calcis), to be retained if possible.

When the hæmorrhage occurs *guttatim* from the mucous membrane of the rectum, the writer has frequently succeeded in arresting it by the application of *nitric acid* of a specific gravity of 1.500. The bleeding mucous surface should be delicately touched with it by means of a fine glass-hair brush or with a wooden spatula. Two or three applications will be sufficient, five days intervening between them. Great care should be observed to confine the application only to the affected bleeding mucous surface, and not let any of the acid come in contact with the fine, delicate, and highly sensitive muco cutaneous tissue about the verge of the anus. Immediately after applying the acid, *olive-oil* should be applied to somewhat modify its action.

When the hæmorrhoidal flux is very profuse and escaping *per saltum* from organized tumors, nothing will succeed in arresting it but the complete removal of the tumors themselves, and it is much easier to arrest the bleeding and effect a complete cure than when the hæmorrhage issues *guttatim* from the whole mucous surface. In the former case there is almost always to be found the dilated extremity of a capillary tube in the tumor if regularly organized and of sufficient age. By removing the tumor or tumors the bleeding, of course, ceases by means of the plastic inflammation which follows the operation and which completely seals the bleeding vessel which supplied it.

In all such cases it is of the utmost importance, for obvious reasons, that the patient should have one regular and easy passage daily, avoiding as much as possible extra straining efforts. If the bowels are obstinately constipated, mild laxatives must be taken in addition to the enemata of cold water. The writer has frequently used the following aperient with advantage in such cases: ℞ *Sulphuris loti, magnesiæ calcin., sacch. lactis*, āā 4 drachms (16 grammes). M. fiat pulvis.

Hæmorrhoidal Flux (*continued*).

Two teaspoonfuls of the powder should be taken whenever indicated. The writer has used *balsam of copaiba* and *oil of turpentine* with good results in the treatment of excessive hæmorrhoidal flux. Acidulated drinks and some of the light wines may be continually used with great advantage during the treatment, together with all means of prophylaxis. (W. BODENHAMER, *New York Medical Journal*, April 25, 1896.)

Hysterical Aphonia.—BOULAY recommends introducing a sound into the larynx far enough to cause a slight spasm or cough, and, removing the sound, have the patient call out the letters of the alphabet slowly and calmly until a sound can be produced, then to count up to 10, then to articulate simple words, and finally to converse. The sound may be introduced a second or third time, if necessary, in order to produce the desired effect. If this means fail, the aphonia is of a rebellious character, and recourse must be had to external or internal electrization of the larynx by means of the galvanic or faradic current for four or five minutes, having the patient perform vocal exercises while the current is being passed. Massage of the anterior portions of the neck, methodical traction of the tongue, rhino-pharyngeal palpation, or autolaryngoscopy are psychical measures that may succeed, as well as compression of the ovaries. If these measures fail, hypnotic suggestion may be tried. General treatment with *strychnine*, *valerian*, the *bromides*, hydrotherapy, or isolation must be associated with the local means employed, while lesions of the nose, pharynx, or larynx, must also be looked after. (*Gaz. Hebd. de Méd. et de Chir.*, March 1, 1896.)

Influenza.—In cases seen early, especially those presenting pleurodynia or pleuritic symptoms, DR. S. SOLIS-COHEN, of Philadelphia, administers the following recipe: ℞ *Salol*, 3 grains (0.2 gramme); *terpine hydrate*, 3 grains (0.2 gramme). Mix. In powder or capsule. One powder or one capsule is given every two, three, or four hours, according to the indications of the case, and this treatment is kept up for from twenty-four to thirty-six, or even forty-eight hours, according to the progress of the symptoms and of lesions, in case the pleura or lung be involved. In the latter case *strychnine sulphate* from $\frac{1}{100}$ to $\frac{1}{30}$ grain (0.00065 to 0.002 gramme), according to the frequency of administration and the urgency of the symptoms, is combined with it. If cough is sufficiently troublesome to require sedatives, *codeine* (from $\frac{1}{24}$ grain to $\frac{1}{10}$ grain—0.0027 to 0.0065 gramme) is likewise added. *Codeine* is especially useful in cases of pleurisy, not only relieving pain, but also seeming to have a certain controlling influence upon the inflammatory process. Its value in inflammation of serous membranes is well known and is, of course, the explanation of the latter fact. (*Philadelphia Polyclinic*, April 4, 1896.)

Neurasthenia.—An excellent nervine tonic and sedative, adapted as a palliative to most cases, is the following: ℞ *Assafœtidæ*, 1 drachm (4 grammes); *acidi arseniosi*, $\frac{1}{2}$ grain (0.03 gramme); *strychnia sulph.*,

½ grain (0.03 gramme); *ext. sumbul*, 30 grains (2 grammes); *ferri subcarb.*, 40 grains (2.60 grammes); *quiniæ valerian*, 20 grains (1.3 grammes). M. Make twenty-four capsules. Sig.: One capsule after each meal. All habitual neurasthenics are, as a rule, below par in blood-formation and nutrition, and will bear with advantage a decidedly increased and nutritious diet. No part of the organism responds more readily or promptly to nutritious and generous diet than the nervous system.

In cases of sexual neurasthenia the quantity of red globules and hæmoglobin is always below the normal standard, and the first procedure is to restore those important constituents. To accomplish this purpose the following combination answers a good purpose: ℞ *Quinine bisulph.*, 20 grains (1.3 grammes); *ferri subcarb.*, 1 drachm (4 grammes); *strychnia sulph.*, ½ grain (0.03 gramme); *ext. damiana*, 20 grains (1.3 grammes); *ext. cinchon. sol.*, 40 minims (2.60 grammes). M. Make twenty capsules. Sig.: One capsule after each meal. Under this remedy there will be observed a progressive improvement in the condition of the blood, manifested in complexion and under the microscope; and in proportion to this there will be improvement in muscular strength, in the tone of the nervous system, in the condition of the mental faculties and spirits, and, lastly, in the powers of virility. These agents should be pressed until the patient becomes a ruddy, robust, hearty, and cheerful man. Then there will be no use for local treatment or specifics. (BEDFORD BROWN, *Virginia Medical Semi-Monthly*, April 10, 1896.)

Ophthalmic Salve.—The following is recommended by W. ALLEN JAMIESON as a non-irritating excipient for ointments in ophthalmic practice: ℞ *lanolini*, 3 drachms (12 grammes); *ol. amygdalæ*, *aq. destill.*, āā ½ drachm (2 grammes). M. If smeared thinly on the lids this occasions no unpleasantness, and it may be employed when it is desirable to use a salve to prevent the lids becoming glued together by any increase of the lachrymal secretion. It is, however, better, as a rule, to add 2 grains (0.13 gramme) of *boric acid* to correct any slight tendency to rancidity, though this is not prone to happen, even if the ointment be kept for a time. In eczema of the lips the salve forms an excellent medium for the yellow oxide of mercury so beneficial in such conditions. Two grains (0.13 gramme) may be added to the ½ ounce (20 grammes). According to the patients, the salve gives a pleasing sensation of coolness without trace of smarting or irritation. Its curative influence is equal, if not superior, to that of any eye-salves prepared with other bases. (*British Journal of Dermatology*, April, 1896.)

Scabies.—JULLIEN, of Paris (*Medical Press and Circular*, April 22, 1896), has successfully treated three hundred cases of scabies with *Peruvian balsam*. This agent contains an essential oil, cinnamein, the vapors of which are extremely toxic for acarus. The patient rubs himself in the evening for a quarter of an hour with the *Peruvian balsam*, and lies all

Scabies (*continued*).

night in a shirt impregnated with the vapor of the acaricide; the next day he takes a soap-bath. This treatment is not more expensive than the classical treatment, and is, moreover, particularly adapted to cases complicated with eczema or other skin affections in persons weakened from cardiac disease, in pregnant women, and in infants.

R. A. Thompson, of Norwich, N. Y. (*New York Medical Journal*, May 9, 1896), states that this remedy is by no means new, as he has used it for several years in the treatment of mild scabies. Vogel, of Dorpat, in 1884, in his work on the "Diseases of Children," speaks of its use as follows: "The sovereign remedy for the cure of scabies, and which has cast all others in the shade, is *balsam of Peru*. . . . The only objection to its use is that the clothes become badly stained, and notwithstanding repeated washings remain discolored for a long time; hence the necessity of using old and worn-out articles. In children under 5 years of age I use this remedy only; in older children, who have only a few pustules, the usual solution, *solutio Vlemingkx* (a lotion of sulphur and lime) may be used like the balsam. With these two remedies thus applied any case of scabies can be cured in three or four days."

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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(End of Editorial Department of Journal for June, 1896.)

EXPERIMENTAL REPORTS WITH GUDE'S PEPTOMANGAN.

Dr. J. S. Perekhan, Lakeside Hospital, Chicago, in the *Chicago Medical Recorder*, May, 1896, gives several very interesting reports of the value of Gude's Peptomangan.

Case 1.—Anæmia —Patient's blood examined, red blood-corpuscles 2,610,000 to the c. m.; hæmoglobin, 40 per cent. She was placed on Gude's Peptomangan, ʒj after meals and dose gradually increased to ʒij, t. i. d. Results: February 18th—corpuscles, 2,900,000; hæmoglobin, 46 per cent. March 10th—corpuscles, 3.310,000; hæmoglobin, 67 per cent. April 1st—corpuscles, 4,200,000; hæmoglobin, 88 per cent. After sixty-three days of treatment, patient considers herself cured, appetite good, no night-sweats, no cough nor headache.

Case 2.—Tubercular osteitis.—January 20, 1896, blood showed corpuscles 2,700,000 to the c. m.; hæmoglobin, 47 per cent. Gude's Peptomangan was usd ʒj t. i. d. Improvement was rapid and decided. February 15th—corpuscles, 3,510,000; hæmoglobin 64 per cent. March 6th—corpuscles, 4,000,000; hæmoglobin, 80 per cent.

Case 3.—Treated South for consumption. Menstruation absent for eleven months. Condition when I was consulted: Face and mucous membranes very pale, slender, below the average height, pulse weak—120 beats per minute. Appetite poor, night-sweats, bowels irregular, dyspnœa on the slightest exertion. Severe cough; expectoration muco-purulent. Examination showed consolidation of upper lobe of left lung and disease in apex of right lung. Sputum contained large number of bacilli. She was given Peptomangan (Gude's) ʒj doses, with 1 drop of creasote after meals. Number of corpuscles when treatment began was 2,815,000, hæmoglobin was down to 45 per cent. After twenty-five days' treatment patient's condition improved wonderfully. She has gained three and one-half pounds, appetite unusually good, night-sweats entirely ceased, cough and expectoration much less. Blood-count: corpuscles increased to 3,600,000; hæmoglobin, 60 per cent. Sputum still contains bacilli and the patient is still undergoing additional treatment for the tuberculosis.

Dr. E. J. Doering reports a case very similar, as also H. D. Peterson one of anæmia.

All reports seem to convince us that in Gude's Peptomangan the physician has a valuable and trustworthy tonic and a reconstructive remedy and a rebuilder of positive merit.

ZUMO-ANANA.

Dr. S. C. Martin, of St. Louis, Mo., in giving his experience with this valuable preparation, says he was recently consulted by Miss C., a stenographer of that city, who stated that she had been suffering with eructations of the stomach, a sense of fullness, pressure, and intense pain in the epigastrium; that a drink of water gave rise to pain, and after her principal meal of the day she would experience great discomfort; that her appetite was usually capricious, and this morbid condition manifested itself at the most unseasonable hours. She suffered some with insomnia; complained of mental lassitude and low spirits. Menses and bowels were regular. Pallor of the skin indicated the existence of anæmic condition. I made the diagnosis of nervous dyspepsia associated with anæmia. Ordered the following:—

℞ Ferri albuminas, ... ℥ss.
Zumo-Anana, ... q. s. ad ℥xvj.
M. Sig.: A tablespoonful three times a day before meals.

Patient called several times each week, and in two days from the time of the first visit she reported that all the distressing symptoms of the stomach had vanished, in ten days later the skin assumed its natural color. Six weeks have elapsed and not one of the symptoms at first complained of have returned.

THE

Universal Medical Journal.

A MONTHLY MAGAZINE
OF THE PROGRESS OF EVERY BRANCH OF MEDICINE
IN ALL PARTS OF THE WORLD.

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Selections from Society Proceedings.

GERMANY.

TWENTY-FIFTH CONGRESS OF THE GERMAN SURGICAL SOCIETY, BERLIN.

A Method of Treating Exstrophy of the Bladder.—In a paper on this subject, POPPERT, of Giessen, remarked on the well-known difficulty of obtaining continence of urine after operation in these cases. If such a result is apparently obtained, it turns out afterward to be only temporary. He believed the failure to be due to secondary dilatation of the neck of the bladder, preventing proper function of the sphincter, and expressed the conviction that he had found a remedy for the trouble. In the case of a boy, 14 years of age, suffering from exstrophy and epispadias, he had operated by Trendelenburg's method, except that he prolonged the urethral canal as far as possible into the bladder itself, following the posterior wall of this organ. In this way he secured the desired result, the patient at first retaining his urine one or two hours at first, and later on as long as three hours. Poppert added that the separation of the symphysis pubis in this case was not great, but that the method would probably give as good results in cases in which the fissure was larger.

KÖNIG stated that he had recently had occasion to employ Trendelenburg's method in two cases of exstrophy of the bladder. Micturition was performed immediately afterward without difficulty, but unfortunately both patients died of pneumonia,—one in six and the other in three days.

KUSTER had not had very favorable results from the method, and at the present time uses, in the treatment of epispadias, a method presented by Passavant in 1890. Having divided the penis on the ventral side between the two cavernous bodies, taking care to maintain a certain distance from the urethra, he freshens the edges of the urethral mucous membrane on the dorsal side of the penis, and, approximating them, pivots around their longitudinal axis the two penile portions, each containing a cavernous body; he then unites them through the urethral groove only, in such a way that the freshened surfaces are approximated in front. He had thus succeeded in closing the urethra in a number of cases, function being satisfactory afterward.

HELFERICH also recommended this method, which he himself has used for a number of years. It has the advantage of also correcting the incurvation, the anterior concavity of the penis, usually characteristic of epispadias.

Nerve-Surgery.—PROF. ANGERER, of Munich, stated that up to the present time only isolated cases had been recorded in which Thiersch's method of tearing out the nerve was employed. A certain number of surgeons are opposed to this method, preferring resection of the nerve. Since 1889 Angerer had practiced Thiersch's method in 26 cases of trigeminal neuralgia, the number of operations reaching 52, on account of the bilateral nature of the affection, the removal of several branches of the nerve, and the recurrence of the neuralgia. Most of the patients had suffered for a long time from the affection and had had only temporary relief from medical and surgical treatment. The results obtained by him were as follow:—17 patients were completely and permanently relieved; 2 were greatly improved, but not entirely cured, and in 7 recurrence took place. Of the patients operated on four years ago, several operations were necessary in 4 cases and 1 patient died, within six months, of an intercurrent disease. Of the remaining 12, recurrence took place in 3 and 7 remained perfectly free from any symptom whatever. Among the cases of recurrence was one that had been operated on by Nussbaum, in which the cicatricial adhesions had rendered torsion and extraction of the nerve exceedingly difficult. The results in so obstinate an affection could be considered as good.

As to the operation itself, it is advisable to follow Thiersch's precept to extract the nerve as slowly as possible, making half a turn of the forceps in a second, as in this way longer fragments are obtained (as much as twenty centimetres) with all the branches. The wound always heals immediately with a favorable cicatrix. The facial paralysis occurring at first disappears after a time; so that the results in this respect are better than with excision and operations at the base of the skull. As the pain is not limited to the diseased branch, but irradiated throughout the others, it is advisable to remove the latter as a prophylactic measure. The operation is entirely without danger. In persistent recurrence intra-cranial extraction is indicated, including the Gasserian ganglion, by Krause's method. Prof. Angerer operated in this manner in one case in 1895 with great success.

PROF. HELFERICH, of Greifswald, confirmed the good results of the operation, which he had performed twelve times. He called attention to a number of points in connection with it. If the nerve is sought for at its issue from the bony trunk and drawn out, by twisting it slowly a large piece may be removed; but, in order to prevent recurrence or to procure as long a period of relief as possible, it is of the greatest importance to remove as long a central fragment as possible. To this end he isolates the nerve at the point of entrance into the bony canal of the inferior maxillary, and there practices torsion. The results are excellent. Slow torsion is of the greatest importance.

Professor Krause, of Altona, did not believe tearing out of the nerve to be the first method to practice in trigeminal neuralgia, for, according to his observation, recurrence took place in more than half of the cases, and there remained nothing but intra-cranial extraction with removal of the ganglion. If, on the other hand, section or resection, which undoubtedly shows some recoveries, be first performed, there still remains as a resource, extraction of the nerve by torsion, and finally extirpation of the ganglion, which is always an heroic operation. He had practiced Thiersch's operation 12 times with 10 recoveries, 1 death, and 1 case still under treatment. He had modified Thiersch's forceps so that the blades were cannelated lengthwise instead of crosswise, thus giving a firmer hold.

Professor Karewski, of Berlin, reported nine operations by Thiersch's method, completely extracting the trigeminal nerve. No recurrences had taken place in any of his cases.

Vaginal Cæsarian Operation.—Professor Duhrssen, of Berlin, described an operation invented by him for extracting a living child without opening the peritoneum. It consists in incising longitudinally the anterior and posterior walls of the vagina, then incising anteriorly and posteriorly the lower segment of the uterus so as to divide the cervix. The operation is naturally not applicable in cases of contracted pelvis, but it is indicated when the cervix is not dilatable, when there is immediate danger to the mother, as in uræmia, and finally in cases of tumors of the cervix,—myoma or carcinoma. In the last-named case extirpation of the uterus can eventually be performed.

Professor Schuchardt, of Berlin, recommended for these cases his paravaginal method, described at the last congress. He had used it in twenty-three cases with only a single death.

GREAT BRITAIN.

British Balneological and Climatological Society.

Mineral Waters in Gout.—Dr. Fortescue Fox read a paper on articular gout and its treatment by natural sulphur-waters. In his experience at Strathpeffer Spa both the acquired and the hereditary forms of gout were favorably influenced by courses of sulphuretted waters, but he strongly deprecated routine treatment or fixed "cures," which generally ended in disaster. Gout in women was nearly always hereditary, the climacteric period unmasking the tendency, unless it had already been manifested. Gout in younger women was sometimes met with in the articulations as recurrent attacks of synovitis in knee or shoulder, and might simulate "rheumatoid" arthritis. "Arthritis," in the author's view, was a term that should be reserved for degenerative diseases of the joints. In this sense there was a form of gouty arthritis met with in later life in which one or more joints (shoulder, knee, or thumb) became affected with degeneration as a result of slight injury. This form of "local arthritis" must be carefully distinguished from the generalized disease.

Dr. Edward Gilbert, of Tunbridge Wells, said that his experience was strongly confirmatory of Dr. Fox's as to a very large proportion of those who had suffered acute gout having at some time had acute rheumatism. In some cases, especially in women, gout was associated with serious disorders of the nervous system, especially asthma and neuralgia, both in the individual and in the family.

Dr. Walter Blaker, of Bognor, who was himself the subject of acquired and hereditary gout, had derived much benefit for the gouty joint from the waters of Llangammarch, in Wales, and Buxton.

Dr. Oliver, of Harrogate, thought he had observed some signs of change of type in recent years toward the asthenic and neurotic manifestations of gout, particularly in women, and especially since influenza began to prevail, seven years ago. The attacks of gout occurring during spa treatment had, in his experience, become much less frequent since the warm immersion-bath had been largely replaced by douche- and spray- baths combined with vibratory massage, and he believed a course of hot baths to be a powerful means of bringing on acute attacks. No uniformly-restricted system of diet should be strictly adhered to if it impoverished the blood or the nerve-centres. Uric acid played a considerable part in the disease, but there was some other unknown factor which probably governed or modified the disease.

Dr. Alexander Haig said that he believed that inheritance in gout was often merely the inheritance of the money necessary to buy meat and wine. He agreed about the use of vegetarian diet in average cases, but in asthenic cases he would not be too strict about diet.—*British Medical Journal*, May 2, 1896.

Edinburgh Medico-Chirurgical Society.

Infants' Foods.—Dr. Aitchison Robertson read a paper on the condition of the carbohydrate element in the so-called "infants' foods." He drew attention to the feeble amylolytic action of the salivary and pancreatic secretions during infancy, and indicated the bearings of this on the administration of starchy food at an early period of life. The amount of sickness and the rate of mortality among hand-fed children was considered. The analyses of the usual infants' foods commonly referred to these as they occurred commercially. Dr. Robertson gave the results of his analyses of these foods after they had been prepared according to the directions accompanying each, and when ready to be administered to the infant. At a very early age starch should never be administered as such, but only after complete conversion into glucose and maltose,—sugars which were easily absorbed. At a later period of life the degree of conversion might be lessened, thus giving, in addition to these sugars, some of the higher dextrins. Still later, by less conversion, the lower dextrins might be given; and soon, until toward the end of the first year, unchanged, well-cooked starch might be given alone. He deprecated the use of pancreatized foods as general foods for infants. The only element in these infants' foods requiring predigestion was the carbohydrate one, and he alluded to the enfeeblement produced in the gastric and intestinal glands brought about by the continual administration of predigested proteid. The only conditions in which pancreatized foods were useful were in cases of gastric disorder or severe exhaustion accompanying or following acute disease. The preparation which he thought most suitable as an addition to cows' milk was wheaten or oat- flour mixed with ground malt. By varying the duration of the cooking the starch of the flour might be converted to any degree necessary, as into sugar entirely or into sugar along with dextrins. The action of the malt on the milk likewise prevented clotting of the milk in the stomach. It was shown that in several of the so-called malted foods the method of preparation or cooking entirely, or almost entirely, prevented the action of the diastase, and consequently the resulting food contained only unchanged starch, along with, perhaps, some of the earlier-formed dextrins. Those foods that had undergone a thorough treatment by malt, and which, therefore, contained no unchanged starch, but only maltose, glucose, and higher dextrins, might form suitable additions to milk when given to infants under 6 months of age. Foods which contained unchanged cane-sugar were to be avoided. Many of the foods consisted solely of the baked flour of wheat, barley, or oats, or combinations of these. If the dextrination had been carried sufficiently far, these might form easily-digested foods. In most cases, however, the degree of dextrination had only been partial, and thus they contained also much unchanged starch. Not a few of the preparations sold as suitable for infants' use were made up entirely of raw wheaten, barley-, or oat- flour, and were manifestly quite unfit for administration to young infants. He indicated how some of these foods might be advantageously used in the various diseases occurring during adult life and senescence, and concluded by stating that he thought the unrestricted sale of such preparations as food for infants should be prohibited by law.—*British Medical Journal*, June 13, 1896.

PATHOLOGICAL SOCIETY OF LONDON.

Hypertrophic Pulmonary Osteo-arthropathy.—MESSRS. THORBURN AND WESTMACOTT demonstrated the post-mortem appearances of a case of hypertrophic pulmonary osteo-arthropathy. This rare disease was described by Marie in 1890, and in the *British Medical Journal* of June 3, 1893, Mr. Thorburn had recorded three examples of the affection—one, a lad, remained under observation until his death, which took place in September, 1895, his clinical symptoms undergoing no material alteration. The post-mortem examination was very complete and showed almost universal osseous and articular change. The lungs, spine, and right suprarenal capsule and right tibia presented evidence of tuberculous disease, though past the acute stage. The skull was much thickened, roughened internally, sclerosed, and devoid of diploë in the facial bones, ribs, sternum, and vertebræ. Except in carious regions and the clavicles no changes were observed; the limb-bones were covered with a rough, porous layer of subperiosteal bone; their compact tissue was sclerosed and their medullary cavities encroached upon by new bone. These osseous deposits were especially marked in the shafts of the bones and at the attachments of the muscles and fasciæ. The shoulder-joints contained an excess of clear, yellow fluid, and the cartilage of the heads of the humeri were eroded, especially at their margin; the synovial membranes were normal. In the hip-joint closely analogous appearances were observed, and the hips and shoulders were all remarkably symmetrical in the extent and distribution of the cartilaginous erosions. The elbow- and knee-joints also formed a symmetrical group containing less fluid than the hip and shoulders, but with similar cartilaginous erosions and with thickening of the synovial membranes. In the wrists, ankles, radio-ulnar, carpal, tarsal, and other small joints, erosions of cartilage, principally marginal, were also found. The general condition was a highly-symmetrical and almost-universal osteoperiostitis of the limb-bones, with a trophic erosion of the cartilages of their joints. The viscera indicated a somewhat extensive, but much subdued, tuberculosis. Mr. Thorburn regarded as unsatisfactory the theory of Marie, which attributed the disease to the absorption of ptomaines from suppurating foci, and found no evidence in favor of Bamberger's view that it was due to venous congestion; while reserving any strong expression of opinion, he was inclined to indorse his own suggestion, based on the clinical appearances, that hypertrophic pulmonary osteo-arthropathy was the result of a diffused, but very mild, tuberculosis of bone.

Mr. Rickman J. Godlee, after noting that one case of hypertrophic pulmonary arthropathy originally so described had proved after death to be one of acromegaly, observed that many different kinds of conditions were apparently included under this heading, and that time was necessary for their subdivision. Some were examples of septic osteo-arthritis. Of this he cited two cases: one was that of a man about 30 years of age, suffering from cough and offensive expectoration of three years' duration; there was marked clubbing of the fingers and apparent enlargement of the wrists and ankles; pain was absent, but there was fever and effusion into certain of the joints; there was no evidence of tuberculosis. In the second case—one of pleurisy and bronchiectasis with empyema—similar enlargements were present and there was effusion into the knee-joints. The speaker had observed the first case of the kind in 1885, and designated it as clubbing of ankles, wrists, and fingers; this case was associated with an old-standing empyema and was completely cured after the removal of a drainage-tube which had slipped into the pleural cavity. Of the first patient referred to in his remarks, skiagraphs had been taken of the apparently enlarged ends of the bones, but no actual increase in size was revealed.—*British Medical Journal*, May 30, 1896.

UNITED STATES.

American Medical Association.

Purification of Water-Supplies.—Dr. George H. Rohé, of Baltimore, in the address on "State Medicine," stated that the most vitally important sanitary problem confronting American municipalities at the present day was, unquestionably, the supply of pure water for drinking and other domestic purposes. The wide-spread prevalence of typhoid fever might be practically looked upon as a measure of the pollution of the drinking-water. Depending, as this disease did, almost entirely upon an infected water-supply, the importance of having the latter of a pure quality was self-evident. In 1894 twenty-five of the principal cities of the United States had an average typhoid-fever mortality of 39.6 for each hundred thousand of population. Those cities which had the largest mortality from this disease were supplied by a highly suspicious quality of drinking-water.

It would be hardly necessary at the present day to insist upon the etiological relation of infected drinking-water to typhoid fever. The numerous epidemics in this country and abroad, which had been studied with so much care by eminent sanitarians, had demonstrated this relation. While cases doubtless occurred in which the disease could not be traced to the water-supply, they constituted the vanishing minority, the overwhelming majority being unquestionably due to infected water.

In epidemics of cholera a similar relation existed between the outbreak and extension of the disease to an infected water-supply. Aside, however, from the production of these specific diseases, pure water, or water free from all sorts of uncleanness, was demanded by the "sanitary conscience" of the public.

In sparsely-settled districts, or where a supply of unpolluted water could be brought from a distance to a large community, it would probably be better to secure such a pure supply rather than purify a source of supply which has been polluted; but in the majority of instances, particularly in the eastern and central sections of the country, the procuring of such an unpolluted supply was practically barred by financial considerations. We were therefore reduced to one of two alternatives,—either to limit as much as possible or to altogether prevent, which was practically impossible, the access of impurities (notably of sewage or excremental matter) to the sources of supply, or else to resort to some method of purification of the water after it had become polluted.

The city of New York had recently chosen the first alternative mentioned by the purchase of ground immediately bordering on the streams furnishing the drinking-water to that great metropolis. By the removal of sources of pollution from the area of land so acquired, the endeavor had been made to secure a pure drinking-water. In Chicago the extraordinary outbreak of typhoid fever from 1889 to 1893 had led to the extension of the intake pipes in Lake Michigan to a distance of four miles from the shore, and the constant diminution of the sewage contamination had reduced the typhoid-fever mortality from 159.7 in a hundred thousand in 1891 to 31.4 in 1894.

A great impetus to filtration had been given by the experiments conducted under the auspices of the Massachusetts State Board of Health in Lawrence, carried out so thoroughly by Mr. Hiram F. Mills and Mr. Allen Hazen. These experiments, conducted with painstaking care for a number of years, proved conclusively that water, no matter how polluted, could be rendered pure by simply filtering it through sand filters, provided certain cautions were observed regarding the construction of the filters, the rate of filtration, and other conditions varying with the character of the water to be purified.

For many years filtration through sand had been used by European municipalities to secure the purification of water. In London most of the drinking-water had been filtered for upward of forty years. The filter-beds of Berlin covered an area of more than thirty acres. In many of the Continental cities the drinking-water was subjected to filtration. The construction and practical management of filters had been investigated with great care. Comparative studies of the efficiency of sand filters and of various processes of so-called "mechanical filtration" had been recently made in Providence, Rhode Island, and in Lawrence, Massachusetts. While the results obtained by different investigators had not been in entire agreement, the prevailing opinion of sanitarians and engineers was that sand-filtration, where it could be adopted, gave the best results in purification at the lowest cost of construction.—*New York Medical Journal*, June 6, 1896.

Exploration of the Brain with a Needle and Syringe through Capillary Holes Drilled through the Skull.—Dr. Edward Souchon, of New Orleans, read a paper on a method designed to take the place of trephining,—*i.e.*, removing a ring of bone before exploring the subdural spaces and the brain. The simplicity of the procedure and its safety recommend it as an easy means within the reach of a greater number than the other comparatively more serious and complicated operation of the trepan. By its ready employment it is expected that many lesions, especially abscesses, cysts, and hard tumors, can be earlier diagnosed and located with certainty after exploring the region suspected from the distant symptoms. It is only in cases of tumors of the same consistency of the brain—that is, soft, but not fluid—that the explorations would be of no avail; but this would also be the case if the trepan were used instead of the drill. Even then, in some cases, the microscopical examination of the particles expelled from the needle might give reliable information. The modus operandi is most simple. Spots of the scalp are disinfected; a puncture is made with a sharp bistoury down to the bone. The drill employed is an ordinary stem-watch drill, to which is added an adjustable guard to prevent unlimited penetration of the drill into the brain-substance after penetration of the bone. When the inner table is reached the drill is worked more cautiously. The perforation of the skull is easily completed with the point of a No. 1 aspirator-needle attached to a syringe. All must be done under thorough asepsis and according to the rules followed in exploring after ordinary trephining. Several holes can be drilled at a distance from one another at the same time. Referring to apprehensions which have been expressed as to the danger of hæmorrhage, the writer cited experiments made by himself on dogs, the brain being several times explored at several places at each sitting without exhibiting any symptoms of hæmorrhage. One of the dogs was killed and no trace of hæmorrhage worth mentioning was found. He reported also post-mortem examinations by Spitzka, Meinchard, and Schmidt of cases in which the subjects had succumbed from the natural course of the original disease and in whom no traces of hæmorrhage were found.

Dr. Thomas H. Manley, of New York, could not agree with many of the points mentioned in this paper. If there is an effusion of blood into the brain, there is no reason why that blood should not undergo rapid resorption the same as it would elsewhere, especially on account of the high vascularity in this region. If it is necessary to explore the skull, we should be ready at the same time to go on and operate, and the anæsthetizing of the patient should be just as complete as for any other operation.

Dr. Nicholas Senn, of Chicago, said that the paper was a very valuable one, but he was compelled to disagree with a number of the ideas which it contained, as the operation described had never given any diagnostic information that he felt he could rely upon. A small perforation is attended with more danger than is opening the skull, just as small wounds often give more trouble than large ones. Temporary resection of the skull combined with a puncture with the needle often yields valuable diagnostic information, and, when doubtful, these may be followed by palpation. The sensation imparted to the finger is also of great value in determining between a solid tumor and a cyst, and increased resistance to the needle will often be of service. In the case of such pathological productions as blood, serum, cysts, or abscesses, the needle may give positive results and may also be utilized as a guide to reach the abscess. The difficulty of sterilizing and properly cleansing the apparatus is an objection to the use of the needle.

Dr. Alex. Hugh Ferguson, of Chicago, considered Dr. Souchon's paper a valuable one, but in his own experience he had not found the use of the needle a reliable method. In cases of hæmorrhage he would prefer to use some other method, as, for instance, gauze packing.

Dr. Souchon, in closing the discussion, said that the use of the needle had frequently proved of great service to him, and that if the size and thorough cleanliness be attended to much good may result from its use.

Surgical Sterilization in Private Practice.—Dr. Edward Boeckmann, of St. Paul, Minn., referred to an address which he read before the Association of Military Surgeons of the United States, on "Asepsis in Military Service." He strongly recommended the 120° F. (48.9° C.) warm and 1- to 2-per-cent. strong solution of lysol for combined mechanical and chemical disinfection of the operator's hands and the patient's skin. Provided with lysol, absolute alcohol, and ethereal solution of sterilized lanolin, we are enabled to disinfect the skin, the most dreaded bearer of infection, as safely as is possible at this time, and with as few and as simple agents as can be demanded in operations in private practice.

All sterilizers for streaming steam must necessarily be constructed for oversteam. Dr. Boeckmann does not favor combination sterilizers, because boiling and steaming are different processes requiring an unequal time.

He uses a combination portable sterilizer, consisting of four parts; the boiling-pan, the hood, the instrument-tray, and the steam-chamber. The boiling-pan is filled with a sufficient quantity of water, care being taken to fill the groove at the same time; the hood is adjusted and the whole placed over a good fire. While the water is heating the instruments are arranged on the tray and the dressings, etc., in the steam-chamber; needles, drainage-tubes, ligating and suturing materials are put (separately) in a small metal box (sterile catgut is brought along in hermetically-sealed envelopes). When the water boils the hood is removed and the steam-chamber put in, whereupon the hood is replaced with a cork in the upper tube. The steam will now ascend between the hood and the steam-chamber to the top The cork at the top and the water in the groove and the pan acting as locks, the steam is forced to work its way through the opening in the cover into the steam-chamber, through the articles contained, and out through the tube in the boiling-pan. In the course of five minutes the instruments are surgically sterile.

Dr. Boeckmann urged all surgeons to consider every wound at the end of an operation of some duration as slightly infected, and therefore to combine their asepsis with a judicial antisepsis. Thus, he is in the habit of repeatedly dipping his hands in a weak, sterile solution of lysol (1 to 2 per cent., or even less). This small amount of antiseptic he has yet failed to find objectionable, and he uses lysol because it is at hand and because it is alkaline. When the operation is completed he applies next to the wound an antiseptic dressing, not exactly the customary iodoform gauze, because its preparation requires unusual facilities; but anhydrous lanolin, first sterilized, mixed while cooling with 2-per-cent. lysol, and run into sterilized tubes, this being first expressed over the wound, whereafter the ordinary dressing is applied.—*Medical Record*, May 23, 1896.

The Frequent Dependence of Insomnia, Mental Depression, and Other Neurasthenic Symptoms upon Diseases of the Gastro-Intestinal Tract.—Dr. Boardman Reed, of Atlantic City, pointed out that these symptoms were admitted to result from the graver forms of disease of the alimentary canal, such as cancer, ulcer, gastric catarrh, dilatation, etc., in consequence of the lower nutrition which these affections induced, from starvation of the nerve-centres consequent on impoverishment of the blood or from poisoning primarily of the blood and secondarily of all the tissues by the products of fermentation, putrefaction, and suboxidation. He showed that, while cancer and ulcer of the stomach were generally recognized at a comparatively early stage, on account of the pain and vomiting which characterized them, gastric catarrh, gastric atony, and dilatation of the stomach were oftener allowed to progress to an advanced and comparatively hopeless stage before they were properly diagnosticated and the patients placed under appropriate treatment. That form of gastric derangement in which an excess of hydrochloric acid is secreted he referred to somewhat at length, because it was exceedingly common, accompanied nearly always by severe neurasthenic symptoms, including especially insomnia, etc., and yet, being only demonstrable by the tube after a test-meal, was very generally overlooked. He dwelt especially upon the almost constant association of superacidity with constipation, and suggested, as an explanation of the connection, that the superacid contents of the stomach, upon passing into the bowel, inhibited or greatly diminished the activity of the intestinal ferments, which required an alkaline or, at least, a neutral medium, and that, besides this serious interference with intestinal digestion, the excessive acidity might set up irregular or spastic contractions of portions of the gut. He had felt these contracted portions in such cases and considered the constipation thus produced an important link in the chain of causes which resulted in self-intoxication.—*New York Medical Journal*, May 16, 1896.

American Pædiatric Society, Montreal.

Cause of Sudden Death after Antitoxin Injections.—Drs. A. Seibert and F. Schwyzer, of New York, gave the results of a series of experiments made by them on animals to determine (1) whether large quantities of fresh antidiphtheric serum brought directly into the blood-current of an animal could produce unfavorable symptoms or death; (2) whether large quantities of old antitoxin could cause trouble when used in this manner; (3) whether air, a quantity of which is found with the fluid in every syringe used for hypodermatic injections, could be a possible cause of sudden death. The authors found that large quantities of fresh and old antitoxic serum injected quickly into the venous circulation of guinea-pigs and rabbits did not cause the slightest reaction. Carbolic acid in 1- and 2-per-cent. solutions injected in from 1- to 4-cubic-centimetre (15 to 60 minims) doses in the same animals invariably caused characteristic convulsions immediately, differing only in intensity and duration, proportionate to the quantity and concentration of the solution.

Air injected into the venous circulation invariably caused difficult respiration, rapid increase in the heart's action, cyanosis, and ultimately death. The intensity and rapidity with which these symptoms appeared were in direct proportion to the amount of air injected into the vein at one time in so far that a larger quantity would cause death quicker than a smaller one; a smaller one injected quickly and at once would kill more speedily than a larger one injected slowlv and at given intervals. A smaller quantity of air might cause speedy death (in five to ten seconds) if passed at once through the right heart into the pulmonary artery, causing complete occlusion, and a larger quantity remaining in the heart might not prove fatal for from five to twenty minutes.

The conclusions drawn from these experiments are that antitoxic serum does not seem to be capable of causing threatening symptoms and speedy death, even when brought quickly into the blood-current in very large doses. The carbolic acid used in preserving the antidiphtheric serum must be in such a weak solution as to be entirely unable to cause the characteristic carbolic convulsions produced in every one of a second series of experiments made by them. The absence of these convulsions in the cases of sudden death in patients, the entirely different group of symptoms reported in them, and the fact that guinea-pigs and rabbits will survive even very large and concentrated doses of carbolic acid injected into a vein lead them to discard the possibility of this drug having caused the reported deaths. Even very small quantities of air will cause severe disturbances and ultimate cessation of breathing in every animal experimented upon. These disturbances are entirely analogous to the symptoms reported as preceding the sudden deaths after antitoxin injections. Air is found alongside of the fluid in every syringe used for hypodermatic injections, and being pressed under the skin with the fluid may readily come in contact with a punctured cutaneous vein, and so may enter the blood vessel and the right heart, even before the serum has been absorbed.

In view of these facts the authors expressed their firm opinion that the sudden deaths reported after antitoxin injections were caused by injected air, and not by the antidiphtheric serum.—*New York Medical Journal*, May 30, 1896.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

The Early Management of Congenital Club-foot.—In a paper on this subject DR. LEWIS A. SAYRE stated that whether the case be one of varus or valgus, calcaneus or equinus, or plantaris, or any of their various combinations, the same general principles of treatment are applicable, and the time to commence their application is immediately after the birth of the child, or, if not present at the birth, as soon after as the case is seen.

There is a prevalent idea among the profession that the treatment of club-foot must not be commenced "until the child is old enough to stand it." This false teaching has produced such an effect upon the laity at large that they do not bring their children with crooked feet to the orthopædic surgeon for treatment until some months after birth. He enters a most solemn protest against this false teaching and urges the profession at large to attempt the rectification of these deformed feet immediately after birth, or, if they have not the time or inclination to qualify themselves to treat the case properly, they should at once advise that the child be placed under the care of some one who will treat it properly.

The method of procedure is for the operator to take the foot in his two hands and gradually, but very gently, press it around toward the normal position. As this is done the toes and front part of the foot will become blanched as white as snow and apparently perfectly bloodless. If retained in this position too long sloughing necessarily follows the obstruction to the circulation. Therefore, after holding the foot in this improved position for a few seconds only, the hold upon the foot should be relaxed, when it will immediately recede toward its former deformed position, and the gradual return of the pink color and the natural circulation to the foot and toes will be seen.

If both feet are deformed (as is generally the case), the other foot must be treated in the same manner as the first, while the first is being restored to its previously deformed condition.

These various manœuvres must be repeated a number of times and the nurse instructed how to do the same properly every few hours day and night.

In addition to the improvement gained by frequent manipulation of the foot or feet, great advantage may be gained by covering the foot and leg with a very soft flannel bandage (leaving the toes exposed for observation), then applying a strip of adhesive plaster partly around the foot and drawing it as far in the right direction as can be borne without interfering with the circulation, which can be judged by watching the color of the toes, and then securing the plaster by a snugly-applied roller-bandage. This plan is to be followed up day by day until the foot can be retained in the normal position without interference with its circulation.

To retain it in this improved position frequently requires artificial aid, and the best that can be adopted is the plaster-of-Paris bandage over a a snugly-fitting flannel roller-bandage. It fits with perfect accuracy, and therefore there is no danger of galling or chafing, and the child cannot kick it off, as it will any kind of a shoe that has ever been invented (even Sayre's own, which he has now abandoned for five years or more). If the feet are very much inverted and the gastrocnemius much contracted, the plaster-of-Paris bandages may be continued above the knee, flexing it a little to shorten the gastrocnemius and strongly everting the foot or feet just before the plaster sets.

In the majority of cases, by adopting the plan here suggested, the child will have his foot facing the floor by the time he is old enough to stand, and then he will cure himself by exercise,—sometimes, of course, requiring the slight aid of an elastic to invert or evert the toes, as the case may be. In some cases, however, there is a structural shortening or contracture of the tissues, and the contractured tissues must here be subcutaneously divided and the foot immediately restored to its normal position, the wound hermetically sealed, and the parts retained absolutely immovable by a plaster-of-Paris bandage for from fourteen to sixteen days, when the wound will have healed and the exudate between the severed ends of the tendon will have become firmly united and of sufficient strength to be of practical utility in moving the foot. Dr. Sayre emphasized (1) the necessity of commencing treatment at birth; (2) that there is no instrument that can be compared with the human hand in rectifying the deformity; (3) that there is no means of retaining the parts in position equal to plaster of Paris properly applied. If the profession at large will recognize these facts, there will be very few cases of hideously-deformed club-foot requiring tarsectomy, cuneiform osteotomy, or any of the other serious operations now in vogue. —*Medical Record*, April 11, 1896.

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND.

Thyroid Feeding of the Insane.—DR. CHARLES G. HILL, in the president's address, referred to the literature of this subject, and said that he had used thyroid extract in forty cases, some of which were acute, some chronic, and some old persons. He had the following results: Unimproved, 8; improved, 12; greatly improved, 14; cured, 5; died, 7. He reviewed a few typical cases and spoke of the effects of the treatment in general. In some cases there were elevation of temperature, gastric disturbances, and albuminuria. He could not say how the remedy acted, but was pleased with his success.

Diagnosis of Insanity by the General Practitioner.—DR. E. N. BRUSH spoke of the ignorance of the average physician in matters pertaining to insanity. He said that the laws of commitment varied in the different States; that in New York, Pennsylvania, and Maryland a written certificate was necessary to commit a person to an insane asylum and two physicians were obliged to sign the papers. Some of the diagnoses were quite absurd. He divided insanity into two classes: (1) those due to inherent brain-defects, among which we class idiocy with certain degenerative forms of insanity, of which paranoia was the great type, and (2) conditions due to diseases of the brain or to disturbances of the physiological function by disease of other organs of the body. Under the second head are included melancholia, mania, dementia, and general paresis. It is difficult to obtain a careful and correct history of a case. Persons will deny any family taint and try to deceive the physician. The general practitioner is not skilled in asking the necessary questions and may be deceived. Even where there is no hereditary history of insanity, the phthisical taint on one side and the neurotic on the other may produce insane offspring. It is well to learn as much as possible of the patient first before seeing him, and then to examine him afterward. An insane person is usually shrewd and crafty, and the examiner must use tact. Note the patient's attitude. Is he ill at ease? Is he quiet? Examine the skin, tongue, eyelids, hair, etc. There is rarely a clear complexion in the beginning of the insanity. Insane persons often give the most lucid and sane answers, and paranoiacs are frequently met who act in the most intelligent manner until their hobby comes up.

DR. HENRY M. HURD said that the general practitioner was not usually familiar with the technical terms of insanity. He cannot tell what he sees. It is sometimes easy to see that a person is insane, but hard to say why this is so. The diagnosis should be made by the general practitioner. Insanity should be studied in the medical schools, but it is rarely touched on and no examination on that subject is held. The certificates that come from the general practitioner are usually correct and the mistakes are occasional only. Another difficulty arises from the fact that many definitions of insanity are legal, and not medical, and the mistake is that the physician tries to show that the patient is legally, and not medically, insane. The legal diagnosis is a delusion and a snare. It is behind the medical. Physicians are often too accommodating, and when friends come and call on the physician and state what they think and ask for a certificate, the physician is sometimes willing to sign one without seeing the patient. The physician should sign no paper unless he has seen and studied the case.—*Medical Record*, May 16, 1896.

American Orthopædic Association, Buffalo.

The Rapid Cure of Rotary Lateral Curvature of the Spine and Other Postural Deformities by Means of Thorough Development and Corrective Exercises with Heavy Weights.—Dr. Jacob Teschner, of New York, present by invitation, in a paper on this subject, expressed the belief that a weak or rudimentary condition of the muscular system was the foundation of this disorder, and that, therefore, the indication was to develop the whole muscular system. He had discontinued the use of all supporting appliances in cases which he considered amenable to the treatment under consideration, because he thought they interfered with the mobility and freedom of muscular action. In his opinion, lack of muscular strength and habitual faulty position were the important etiological factors. All the exercises with light weights should be conducted before a mirror, so that faulty position and faulty methods of exercising might be readily guarded against. At each visit the patient is put to his individual limit of exercise, and this limit is ordinarily increased at each subsequent visit. The speaker said that he had succeeded by this method of muscular development in curing cases of lateral curvature in which bony and ligamentous changes were present, with marked rotation. The heavier the weight put above the head, the greater the temporary reduction of the deformity, and the frequent repetition of the upward and downward movements tend very markedly to increase the development of the chest. Out of 21 cases of lateral curvature that he had treated by this method, 19 were curved and 2 were very much improved at the time the treatment was discontinued. Most patients could stand with advantage three treatments a week, and in the milder cases improvement was quite noticeable within two weeks. The increase in the person's height was often quite rapid, and an existing flat-foot would be made shorter through shortening of the inner arch. The advantages claimed for the method were: (1) rapid improvement in the general health and in the muscular system; (2) marked increase in the lung-capacity; (3) diminished frequency of the heart's action and increase in the pulse-pressure; (4) a continued improvement, both in the general health and in the condition of the muscular system for a long time after active treatment ceases.

A young man who had been under this treatment for stoop-shoulders was used to demonstrate the different exercises. At the beginning his pulse was 60 and the radial pulse-pressure 165 millimetres of mercury. The exercises were done rapidly and without the usual rests between them. After the completion of these exercises and a rest of about half an hour, the pulse was 96 and the pulse-pressure 210 millimetres of mercury.

Dr. S. Ketch, of New York, said that he was not yet convinced that it was necessary to subject a child or adolescent to such severe exercises in order to effect improvement or cure of a lateral curvature. The only proper test of benefit or cure was the amelioration or removal of the element of rotation. Our object should be to secure by exercises an increased lateral flexibility of the spinal column. His own experience was directly opposed to Dr. Teschner's statement that this element could be improved in a very short time. A combination of the milder gymnastic exercises with the use of retentive apparatus seemed to him to constitute the best method of treatment.

Dr. John Ridlon, of Chicago, said that he had tried Dr. Teschner's method in one case, that of a rather delicate girl of 16, who had been having milder exercises for about six months previously. Even by a very gradual increase in the daily heavy exercises he had not been able to get her to put up more than a five-pound dumb-bell, and that for only five times at most. The treatment was persevered in for four or five weeks, but, as no improvement was noted, it had been then entirely abandoned. Theoretically, he saw no reason why these heavy exercises should be more potent in increasing the lateral flexibility of the spine than the milder ones; he would expect it to be the reverse. The speaker then proceeded to criticise the photographs presented in connection with the paper, both as regards the seeming tendency to place the patient in the worst possible position for the first photograph, and in the best possible position for the photograph taken after the treatment, and the omission of photographs of cured cases.

Dr. R. H. Sayre said that he did not believe that the development of one set of muscles necessarily meant a lack of development of other muscles. Development of muscular power was only one of the means at our command for the correction of any individual case. He could not agree with Dr. Teschner that supporting apparatus should be abandoned. In view of the fact that there were no recorded cases of cures of lateral curvature associated with bony distortion, he thought it very unfortunate that no photographs had been exhibited of the nineteen cases claimed to have been cured. These heavy exercises should be capable of increasing the general muscular development, but they were not without danger in frail children, and he believed that there were safer and equally efficient methods of treatment. The statement that the patients continued to improve after the cessation of the exercises was certainly at variance with general principles.

Dr. A. J. Steele, of St. Louis, said that he was convinced that the method was of some value, and his proposition to test its capabilities—the selection of four judges to separately examine an adult patient both before and after the treatment—was certainly a fair one.

Dr. Harry M. Sherman, of San Francisco, said that all would agree with Dr. Weigel that the superincumbent weight was the chief etiological factor, but the question was: Why should there be a bone in the body which was abnormally weak? He also felt disposed to criticise the incompleteness of Dr. Teschner's records, and the fact that the only proof of improvement or cure offered was the tracings and photographs. It would at first sight seem that the taking of the tracings by different men was a safeguard against bias and error, but second thought would show that this in itself introduced another element of error,—the personal equation of these men. He considered the use of mirrors as a guide to the proper performance of the exercises a valuable addition.

Dr. A. E. Hoadley, of Chicago, said that the intervertebral discs represented one-fourth of the spinal column, and when these discs were deficient in "cellular tension"—in other words, were debilitated—they would become depressed, as shown by a reduction in the person's stature. He had known this to amount to as much as one and one-eighth inches between the time of rising in the morning and going to bed at night. This certainly meant a relaxation of the ligaments of the spinal column, thus allowing a certain amount of rotation. He had found that in perfectly healthy individuals the decrease in stature in the day was not more than one-fourth of an inch, and that, when the shortening exceeded half an inch, deformity was invited. He believed that the rapid development of muscular tonicity would interfere with the correction of the deformity and in many cases would make it impossible.

Dr. W. E. Wirt, of Cleveland, agreed with Dr. Teschner that these heavy exercises tended to increase the flexibility of the spine.

Dr. Hanna, of Oberlin College, said that she had been accustomed to treat lateral curvature in young girls by mild gymnastic exercises, massage, and the use of the hot and cold douche. Three months were ordinarily required to bring up to a proper standard the muscular system of a person deficient in muscular power.

Dr. Weigel said that the question of mechanical support was one of individual opinion and preference. Personally, he did not believe their disadvantages were so great as had been claimed. He found it hard to believe that the muscles grew strong as quickly as one would infer from Dr. Teschner's statements.

Dr. Teschner, in closing the discussion, said that he had not taken photographs of all his cases, for he did not think that they were of any value in the cases of mild postural scoliosis. In having the various patients photographed, he had not attempted to place them in any special position, but had merely told them to stand before the screen and be photographed. One of the photographs that had been especially criticised was that of a person who had been utterly unable to stand in such a good position before the treatment. He had asked Drs. Whitman, Gibney, Ketch, and Judson to act as the four judges in the test-case already referred to.

Spontaneous Dislocation of the Hip.—Dr. William J. Taylor, of Philadelphia, reported the case of a man, first seen by him when 21 years of age. When 5 years old he had fallen, but no injury to the hip had been detected at the time, and he had run around as usual. The first sign of any trouble with the hip had been noticed about six months after this. Careful examination by the speaker disclosed a typical dislocation of the head of the femur on the dorsum of the ilium, without evidence of inflammatory changes. Apparently the fall had caused an effusion into the joint, causing a distension of the capsule, and thus giving an opportunity for the occurrence of the dislocation. With the aid of a high shoe the man was able to walk with considerable comfort. As the dislocation had existed for nearly fifteen years prior to coming under observation, no attempt was made to reduce it.

Similar cases were cited by Drs. R. H. Sayre, Goldthwaite, Ridlon, and McKenzie.

Dr. Taylor, in closing, said that as there had been no lameness or limp of any sort for six months after the fall it seemed almost certain that the dislocation did not occur at the time of the accident.—*American Medico-Surgical Bulletin*, May 30, 1896.

AMERICAN GYNÆCOLOGICAL SOCIETY, NEW YORK.

Virginal and Senile Endometritis.—DR. PAUL F. MUNDÉ, of New York, presented a paper on this subject. He said that he had met with a number of cases in which there had been chronic catarrhal inflammation of the virgin uterus, and even such marked eversion of the cervical lips as to give the appearance of an ordinary puerperal laceration of the cervix. While, of course, the rule was that the gynæcologist should not hastily resort to local interference in young virgins, there was sometimes a tendency to carry this rule too far, and so bring needless suffering and disease upon the patient. He recalled several cases illustrative of this, and showed how, in suitable cases, simple local measures would bring speedy and complete relief. In the cases under discussion there was usually more or less muco-purulent vaginal discharge, and sometimes menorrhagia, but a correct diagnosis could only be made by a specular as well as a digital examination. In most instances the excision of the hypertrophic mucous membrane and curetting of the endometrium would effect a cure. It was not uncommon for women who had passed the change of life to have a muco-serous and pungent discharge from the cervix, due to a senile endometritis. The discharge soon caused erosions, which were best treated by the local application of solution of nitrate of silver ½ to 1 drachm (2 to 4 grammes) to the ounce (31 grammes). Sometimes the discharge was sanguineous, and then a positive differential diagnosis between endometritis and malignant disease could only be made by microscopical examination. In none of the cases coming under the scope of the paper had he felt that a severe operation like vaginal hysterectomy was indicated.

DR. A. LAPTHORN SMITH, of Montreal, said that he believed that the dysmenorrhœa and menorrhagia from which many young girls suffered were due to endometritis, and, in his opinion, the chief causes leading to this condition were tight corsets, exposure of the feet to wet and cold, and also chronic constipation.

DR. MATTHEW D. MANN, of Buffalo, said that in his address before the society last year he had directed attention to the fact that underlying a virginal or senile endometritis there was frequently a condition of malnutrition, spoken of in a general way as "lithæmia." If the physician failed to recognize this condition and to institute appropriate constitutional treatment, he would find that these cases would almost invariably relapse.

DR. CHAUNCEY D. PALMER, of Cincinnati, said that he too had seen several cases of virginal endometritis in which, notwithstanding the presence of all the usual signs of virginity, the eversion of the cervical lips closely resembled the condition found in puerperal laceration of the cervix. Relief had been offered in these cases by tracheloplastic operations.

DR. HOWARD A. KELLY, of Baltimore, had never seen a case of endometritis in a person who was undoubtedly a virgin and who had not been subjected to previous local instrumentation. In the senile cases he had usually found the inflammation limited to the cervical mucosa.

Dr. W. T. Lusk said that, in young virgins suffering from backache, dysmenorrhœa, and menorrhagia, examination under chloroform would usually disclose an extremely small os internum and erosion and partial closure of the os externum. As a result of this, there would be slight dilatation of the uterine cavity. It was only necessary to thoroughly dilate the os externum to allow of the escape of the retained secretion, and so relieve the symptoms from which the patient suffered.

Dr. Johnson, of Washington, D. C., referred to the importance of knowing that there might be these lacerations or clefts in the lips of the cervix irrespective of parturition, and that they did not necessarily indicate that there had been any lapse of virtue.

The Clinical Importance of the Menstrual Wave.—Dr. Arthur Johnstone, of Cincinnati, expressed himself as a thorough believer in "the Stephenson wave," and in the far-reaching therapeutic possibilities flowing from a proper appreciation of the relations of this menstrual wave not only to gynæcology, but to general medicine. He believed that in the trough of the wave the pelvic organs became anæmic and shrunken, and that this caused a mechanical stretching of nerve-filaments, and, therefore, pain. He did not think one should operate just before a menstrual period, except where there was some special urgency. There was not a functionating organ in the body, he said, that was not liable to become deranged if the menstrual wave were disturbed. Many sins against the ovary would be avoided by proper attention to the menstrual wave.

Epilepsies, and mental derangements of all kinds, having a periodicity, should be most carefully studied in women with reference to their relation to the menstrual wave. In the Toledo Asylum it had been found that only about 5 per cent. of the female lunatics were insane from pelvic causes.

Dr. A. J. C. Skene, of Brooklyn, said that he could not accept Dr. Palmer's statement regarding the greater liability of women to disease because of their delicate organization, because it was an undoubted fact that they were exempt from many of the nervous organic diseases to which males are subject. Not long ago it had been believed that many cases of epilepsy could be cured by the removal of ovaries obviously pathological; now, the neurologists assert that they do not believe a case of true epilepsy has ever been cured by any operation on any organ of the body. He had found Stephenson's ideas about the menstrual wave by far the most valuable guide in his clinical work.

Dr. Engelmann, of St. Louis, said, regarding the relief of various nervous conditions in women, that his experience had been that such conditions were more under the control of the uterus than of the ovaries.

Dr. Palmer took exception to only one part of Dr. Johnstone's paper, —in regard to the causation of intermenstrual pain. His own belief was that it was due to ovulation occurring in an ovary whose cortex had become pathologically thickened.

Dr. Johnstone said that, as only about five ovules appeared to ripen in the course of a year, he could not understand this explanation of intermenstrual pain, nor had he ever seen a case of intermenstrual pain relieved until the menopause had been established.—*American Medico-Surgical Bulletin*, May 30, 1896.

Clinical Notes and Lectures.

Creasote in Tuberculosis of the Upper Air-Passages.—Dr. Walter F. Chappell, of New York, has, during the past three years, used creasote in the treatment of thirty-two cases in which there were tuberculous deposits in some part of the upper air-tract. For internal administration, equal parts of beech-wood creasote and compound tincture of gentian, thoroughly mixed in hot milk, have been the most satisfactory in his hands. This combination produces little or no discomfort, even in large doses. Some of his cases had the daily dose gradually increased until ninety drops were taken during the twenty-four hours, and in none was the use of creasote discontinued from stomachic or intestinal disturbances. For local use, pure creasote and its solutions in alcohol were found to be too irritating. Solutions of creasote in castor-oil were preferable to all others. These solutions are viscid and tenacious, and therefore especially serviceable for local use. For administering submucous injections of creasote, nothing equals, in his experience, the automatic syringe and guarded needle already described by him. To give satisfactory injections with an ordinary syringe, he is convinced, is impossible. In choosing an automatic syringe for laryngeal work it is not necessary to have a strong, stiff spring. Care should also be taken that the thumb-catch, which disengages the piston, works readily; otherwise the advantages of the syringe are not obtained. He emphasizes that in using the syringe we should be certain that the injection is a submucous one, and that the solution does not well up around the needle.

For local applications of creasote he previously recommended absorbent cotton on a laryngeal applicator as an effective method; but from further experience he has doubted the propriety of this in acute cases, and has resorted to the use of droppers. With a Mizpah dropper and laryngeal mirror solutions may be dropped in exact quantities into any part of the larynx.

An oral cavity with a long antero-posterior diameter requires droppers of greater length than those usually found in the market. These may readily be obtained from any druggist familiar with glass-blowing. Patients are quite easily taught to use the long droppers, and can themselves make laryngeal applications without difficulty. Weak solutions of creasote are preferable for these applications.

In acute pulmonary tuberculosis, with profuse expectoration, quantities of mucus cling to the larynx and walls of the trachea. In view of the possibility of this being a source of infection to the mucous membrane, the author asks whether applications of creasote may not be a reasonable precautionary measure.

Dr. Chappell believes that there can be no doubt that the action of creasote, internally and topically, is beneficial at some period in many cases of tuberculosis of the upper respiratory tract. In one of his acute cases the changes were remarkable, although, on the whole, the greatest relief and progress were obtained in the chronic cases. Small ulcerations are decidedly affected by creasote. When the ulceration is extensive and progressing, creasote will occasionally produce cicatrization ; in others it limits the ulceration and modifies the pain and discomfort. In advanced cases nothing can take the place of cocaine for the relief of pain. In the writer's opinion, the benefits from creasote are as permanent as from any other form of treatment, or as it is possible for them to be in a disease which is usually secondary to a similar condition in the pulmonary organs. Of course, in giving injections one cannot always be sure that every point of deposit has been reached. Appearances and symptoms may lead us to this favorable conclusion, and still a spot of infection may lie dormant until some renewed activity in the pulmonary organs rekindles it. Again, although every particle of tuberculous deposit may have been reached and the larynx left apparently healthy, re-infection may occur so long as there is any disease in the lungs.—*New York Medical Journal*, May 9, 1896.

Deformity of the Uvula in the Insane.—Having noted that the uvula was bent sharply to the right or left in a number of his patients, DR. CHARLES L. DANA, of New York, examined that organ in the degenerate classes, and gives the result of his investigations in the *American Journal of Insanity* for April. He finds that the uvula varies in shape, being very long, very short, very thick and large, or very thin and small. Sometimes it is connected with the pillars of the fauces, forming a " webbed " uvula. It may be curved, double, bifid, or hypertrophied, the latter from disease.

Dr. Dana has examined 108 insane patients with regard to the shape, size, and innervation of the uvula, and found the total number of deformities to be 53, or almost 50 per cent. The commonest peculiarity was a twist to one side, about equally to the right or to the left, but a little oftener to the left side. The total number of patients with a twisted uvula was 32, or not quite 31 per cent. The proportion was much greater in the degenerative forms of insanity, the number being 19 among 35 cases, or over half, as against 13 in 69 cases of acquired insanity. Thus, just in proportion as the physical stigmata of degeneracy were more marked the proportion of deformed uvulæ increased.

Hypertrophy and elongation of the uvula were not abnormally frequent, and they were not commoner in the degenerative than in the non-degenerative types. Bifid uvula was not found in any case. This agrees with Dr. Dana's view that cleft palate is not a stigma of degeneration, properly speaking, and implies no defect in nervous organization. It is merely an accidental disturbance in bony development. There are other so-called stigmata which should not be called such.

As regards sex, the proportion of twisted uvulæ in the men was 32 per cent. and in the women 29 per cent. Among the degenerative insanities, however, deformed uvulæ were more frequent among women, being 8 in 14 women, as against 11 in 25 men. In his cases at Bellevue degenerative insanities are more frequent among men ; and this corresponds to the well-known fact that women vary less from the normal type and have a smaller percentage of degeneracy.

As regards innervation of the uvula, of 51 cases the uvula contracted in 24 cases and was motionless in 27. In normal persons the uvula is almost always innervated, contracting promptly when the patient says "Ah" or when the fauces are irritated. Hence, a defective innervation of the uvula may be considered a mark of inferior or incomplete nervous development.

Dr. Dana examined 57 neuropathic patients who were suffering from various forms of nervous disease, such as neurasthenia, hysteria, epilepsy, alcoholism, tabes dorsalis, spasmodic disorders, etc. Among them he found 3 bifid uvulæ (1 imperfectly so), 13 twisted, and 1 supernumerary. The proportion of twisted uvulæ in them is, therefore, 22 per cent., as against 31 per cent. in the insane. With regard to normal persons, Dr. Mary E. Henessey examined nearly 100 throats, with negative results. She stated that the uvulæ were so monotonously regular that the investigation lacked interest.

Dr. Dana examined 54 persons who were not neurotic, and found 1 in 8 (13 per cent.) with an abnormal uvula. The percentage in phthisis is larger, and phthisical persons usually show a large proportion of degenerative stigmata. The innervation was observed in a series of 30 normal persons (10 women and 20 men), and the muscles contracted in 22 cases (73 per cent., as against 47 per cent. in the insane). In 5 cases the uvula was much elongated. A bifid uvula was found twice among the 54 cases. In 1 instance it was double, rather than bifid, the two parts being widely separated and each well innervated. The patient was a young woman who suffered from a congenital heart-lesion which caused morbus cæruleus.

The palate was examined for deformities, such as torus palatinus, Gothic arch, etc., but notes were made of the torus in only 86 cases of insanity. The total number of instances in which there was a decided torus was 24, or 28 per cent. Here, also, the proportion was much greater in the degenerative types of insanity, being 12 in 28 cases, or nearly one-half, while in the acquired forms there were 12 in 58 cases. Slight degrees of torus, and even the sharp, narrow torus, are of not much significance ; the broad, long torus is the real stigma.

Dr. Dana thinks that he can safely conclude, from the results of his inquiry, that the existence of a uvula twisted to one side and not innervated forms an anatomical and physiological stigma of degeneration. The twist or bend implies an unequal development of nerve-supply of the two sides, and the degenerate uvula is, as might be inferred, one that has an unequal and defective nerve-supply. In the throats of more than half the degenerates the azygos muscle makes no response.—*New York Medical Journal*, May 16, 1896.

The Limits of Age for Cycling.—One of the most frequent questions which have to be answered with regard to bicycle-riding is what age is it safe to allow a child to learn, and at what age an adult should be warned that it is not safe for him to commence a new exercise. Each case that comes under observation must, of course, be judged on its own merits; but, soundness in wind, limb, and constitution being granted, the experience of the last twelve years suggests to Dr. E. B. Turner, of London, the following general principles on which a decision may be arrived at:—

In the first place, no child under the age of 7 years should be permitted to learn under any circumstances, and very great care must be taken that any boy or girl of that tender age becoming a rider is properly fitted with a suitable machine, and that the pedals, handle-bar, and saddle are so adjusted that he can sit properly upright and use his strength to the best advantage without distorting his body or injuring his growing tissues. The crank should be short—four and one-half inches are ample—and the gear low, and the "reach" so short that when the child is sitting easily on the saddle he can place his heel on the pedal when at its lowest point. The handle-bar must be raised to such an extent and the handles so brought around that they can be conveniently grasped when the forearm is nearly fully extended and the trunk erect. The saddle must be of a proper size, and so adjusted that the peak does not cause any undue pressure; and, when all these preliminaries are fulfilled, the strictest supervision must be exercised to insure moderation as to the distances ridden and pace are observed. All hill-riding, except up a very slight incline, and all excessive speed should be forbidden, and the great test after a ride is the condition of the child the next day. If he eat well, sleep well, and is bright and lively, he has not done too much and is likely to reap benefit and suffer no harm from his exercise. These rules apply, of course, equally to males and females, and from the age of 7 upward leave to ride may always be given to a person not otherwise disqualified by constitutional or accidental causes.

It has been suggested by a French physician that no woman who is "the mother of a family" should ever be allowed to cycle. This is entirely opposed to the experience gained in England. Numerous women, mothers of many children, ride daily, and their reward is increased and renewed health; and the fact that a woman has had children should be no bar to her commencing this pastime unless she suffers from some organic lesion of the pelvic organs, the result of childbirth.

When a person has been riding for some time and has regularly kept up his condition by constant practice, there is no reason why advancing years should compel him to give up his recreation and his exercise. There are within the personal knowledge of Dr. Turner scores of men who have passed the age of 60 years who are still capable of forty or fifty miles a day without fatigue, and the number of those who, though past the "three score years and ten," attribute their continued health to the regular use of their bicycle or tricycle is not inconsiderable. He would be a rash man who, without some very good and definite cause, ventured to debar his somewhat aged patients from an exercise which suited them and which is so adapted to persons who cannot walk much; for it must always be remembered that a man on a bicycle has not to carry his own weight, it is rolled on wheels for him—and the difference there must be in the exertion when a weight has both to be supported and propelled and when it is only propelled on any kind of carriage is apparent. An habitual rider, therefore, may be allowed to use his wheel as long as nature will allow him, and, the more regularly he uses it within reason, the longer will nature allow him the use of it. Whether a man over 65 or 70 may begin to learn is another question, and the almost necessary falls which the beginner must face and the brittleness of the neck of the femur in old people must be considered, as well as the degenerated muscular fibre and atheromatous vessels, which may resent any new and unaccustomed strain. But experience again teaches that if these pitfalls can be avoided good may come from the easy and regulated exercise. Two years ago a gentleman, then aged 68 years, commenced to ride, and since then he has covered nearly two thousand miles on a bicycle, with the result that a chronic bronchial catarrh and numerous patches of gouty eczema have together disappeared. Five years ago a sufferer from almost continual lumbago trusted himself to the wheel, and now in his seventy-fifth year rides twenty or thirty miles a day, and never knows a days illness. The late Major Knox Holmes exchanged his arm-chair and chronic rheumatism for a tricycle at the age of 74, and in his eighty-fourth year rode one hundred miles in the day on the North Road, and died of influenza at the age of 85.

Each case, then, of an old man wishing to cycle must be carefully considered and judged on its merits, always remembering that those who wish to take up a new exercise at that time of life are those for the most part who have lived a well-ordered and active life, and therefore are capable of more than those whose earlier days have been passed in "slothful ease."—*British Medical Journal*, May 30, 1896.

Closure of the Coronary Arteries.—The frequent association of coronary disease with sudden stoppage of the heart's action has long been recognized, but much doubt has existed as to the precise reason for this result and as to the relative importance in its production of the different branches of the coronary arteries. In the hope of answering these and other questions of less pathological moment, PORTER (*Journal of Experimental Medicine*, vol. i, No. 1, 1896) has carried out an exhaustive experimental investigation of the effect of mechanical closure of the coronary arteries of dogs. He found that complete closure of all the coronary arteries was in every case speedily followed by complete arrest of the heartbeat. This result was less constant when only one of the branches was occluded, the frequency of arrest being directly proportional to the size of the vessel occluded. Thus, of sixty-seven experiments upon this point, arrest followed ligation of the ramus circumplexus in 64 per cent. of the cases, of the ramus descendens in 28 per cent., of the coronaria dextra in 14 per cent., and was not observed at all after closure of the branch in the septum.

That the stoppage of the heart is not the result of mechanical violence incidental to the ligation was shown in a number of ways, notably by the fact that it occurred as frequently when no injury was inflicted, closure of the vessels being obtained by the introduction of a glass rod into the coronary artery through the innominate artery and the sinus of Valsalva. And it was also noticeable that the frequency of arrest after ligation was inversely proportional to the amount of destruction of the heart-muscle, the circumplex branch being that most readily ligated.

In all cases in which arrest finally occurred there was distinct diminution in the blood-pressure almost immediately following the operation, the heart quickly became engorged with blood, and within a very short time fibrillary contractions of the heart-muscle were observed, which persisted often for some time after the complete cessation of any co-ordinate beat. These are believed by Porter to depend upon the persistence of a certain degree of contractility in the muscle-fibres after loss of the power of co-ordination by the more highly organized nervous mechanism.

The whole effect of closure of the coronary arteries is attributed to anæmia, the various branches of the coronary arteries being physiologically, if not anatomically, terminal arteries. It is an interesting fact that in several of the experiments removal of the obstruction to the coronary circulation and emptying of the engorged heart by rhythmical massage were quickly followed by return of the normal heart-action.—*American Journal of the Medical Sciences*, May, 1896.

The Effect of Borax on the Curdling of Milk.—Dr. F. J. Allen, Professor of Physiology in Mason College, Birmingham, states that one of the effects of adding borax to milk is to render it incapable of curdling, but the curdling property is restored on the addition of a small quantity of calcium chloride. He has frequently observed this condition in commercial samples of milk. Having made a number of laboratory experiments for the purpose of ascertaining the quantity of borax necessary to prevent curdling, he finds as a result: 1. That milk containing one-tenth of its volume of cold saturated solution of borax is incapable of curdling with rennet (this is equivalent to about 36 grains—2.33 grammes—borax to 1 pint—0.5 litre—milk); smaller quantities of borax delay the curdling more or less. 2. That the addition of calcium chloride either before or after the rennet restores the normal curdling power. 3. That boric acid added to milk does not delay curdling with rennet, but rather hastens it. The effect of boric acid seemed to indicate that the loss of curdling property in presence of borax was not due to the boric portion of the salt, but rather to its soda. He therefore tried the effect of adding sodium bicarbonate to milk. The results were as follow: 1. Curdling with rennet is prevented by adding to the milk one-sixth of its volume of a 5 per-cent. solution of sodium bicarbonate. Smaller quantities retard curdling. 2. The addition of calcium chloride restores the curdling property apparently more quickly than in the case when borax has been used. From these experiments it appears that the prevention of curdling may be due to the removal of the lime-salts from the field of action, but is more probably due to the formation of a soluble compound of the casein and alkali, which is decomposed by calcium chloride in excess. If borax remove calcium from the field of action, it follows that not merely the curdling function will suffer, but also many other functions of the body in which calcium is needed. And even if the alkali of the borax is the only restrainer of curdling, it is not desirable to neutralize the gastric juice by its use. Moreover, the presence of borax may prevent the normal production of acids by fermentation and thereby further hinder digestion. *Lancet*, May 30, 1896.

Descending Optic Neuritis following Nasal Treatment.—Dr. Adolph Alt, of St. Louis (*American Journal of Ophthalmology*, vol. xii, No. 9), records a case of this kind in a man, 38 years of age, who had been treated for nasal catarrh and narrowing of the left nasal passage, the galvanocautery having been applied several times. The patient had noticed that he could not see as well as usual with the left eye, and remarked so to his physician, but the treatment was persisted in and two days later he awoke to find the eye blind. When seen that day by Dr. Alt there was doubtful perception of light; the pupil was dilated and scarcely reacting. The margins of the optic papilla were almost invisible, the retinal veins were hyperæmic, and the arteries thin. Tension was normal.

The nasal treatment was stopped. On the third day the patient counted fingers at one foot, and on the sixth day at five feet, with considerable increase of the field. A few days later injections of strychnine were commenced, and by the eighteenth day he had regained vision $= \frac{20}{\text{xxx}} +$, the field being still somewhat narrowed except upward and outward. The arteries were still thin and papilla almost white.

Afterward Dr. Alt learned that the patient had had syphilis, and he thinks that to this was in some measure due the severity of the attack; but that it could only be accused of being an indirect cause of the trouble by rendering the patient more vulnerable, since only the eye on the affected side was involved, and it improved promptly on mere cessation of the nasal treatment.

Albumosuria.—In a contribution to our knowledge of albumosuria, Prof. M. L. Harris, of Chicago, offers the following conclusions :—

1. True peptone being very rarely, if ever, found in the urine, the term "peptonuria" should be substituted by the term "albumosuria."

2. The albumoses are produced by the digestive or peptonizing action of microbes on the albumins of the body.

3. This digestive action is one common to all forms of living organisms.

4. The albumoses are produced in quantities much in excess of what are appropriated by the microbes for their growth and development.

5. The albumoses being readily diffusible, the excess in production is quickly absorbed by the blood, where, being toxic, and thus acting as foreign bodies, they are eliminated by the kidneys and appear in the urine.

6. Albumosuria may be present in any condition or disease due to the action of micro-organisms within the body, and is thus simply indicative of an infective condition.—*American Journal of the Medical Sciences*, May, 1896.

Recent Suggestions in Therapeutics.

Acne Rosacea.—The treatment found most successful by DR. R. ABRAHAMS, of Mt. Sinai Hospital, New York, consists of local subcutaneous injections of 95-per-cent. *alcohol.* The part is compressed with the fingers, and 20 or 30 drops of *alcohol* injected with a clean hypodermatic syringe with a thin needle. The immediate effect of the injection is a swelling and anæmia of the area subjected to it, lasting but a few moments; next there is an increased redness lasting from half an hour to three or four hours; this gradually disappears, and the treated skin-area assumes normal color. The dilated blood-vessels and papules will be found, after repeated injections, to undergo slow, but sure, obliteration, until finally the whole lesion disappears and the affected integument appears normal. The treatment, in some cases, lasts eight or ten weeks; in others, a great deal longer. (*American Medico-Surgical Bulletin*, May 16, 1896.)

Alcohol in Cancer.—HASSE, of Nordhausen, has used injections of *alcohol* for more than twenty years in the treatment of inoperable cancer, and four cases of this kind in his practice are now cured. He uses the same method in cancer of the breast, and believes that cure could be effected in these cases by surrounding the breast with cicatricial tissue by means of *alcohol* injections. It is preferable, however, to extirpate the breast and treat recurrences by the injections. In this manner he obtained radical cure in a case declared inoperable by Volkmann. (*Semaine Médicale*, June 6, 1896.)

Artificial Serum in Infectious Diseases.—M. LEJARS states that large doses of artificial serum injected into the veins, in cases of acute infection and in cases of confirmed infection, produce most favorable results. In the most dangerous conditions these injections are always followed by a period of calm, and the symptoms are slightly modified. This slight amelioration must not be neglected, inasmuch as it is possible that it may lead the way to cure. In urgent cases venous injections are preferable to hypodermatic. (*British Medical Journal*, May 30, 1895.)

Cocaine Anæsthesia.—M. RÉCLUS reported that he had made a comparative study of *cocaine* and *guaiacol*, using them side by side in operating, and finding that anæsthesia was complete in the part which had received the injection of *cocaine*, while the sensibility was not entirely abolished in the region submitted to the *guaiacol.* The accidents attributed to *cocaine* were, in his opinion, due to the operator, and not to the drug, and could have been easily avoided if the indications he had repeatedly laid down had been followed. These consisted in employing only 1-per-cent. solutions, never exceeding the total dose of 3 to 4 grains of *cocaine*, always placing the patient in a recumbent position, and avoiding penetration of a vein. By observing these rules he had been able to practice 3500 operations without one accident, not even once observing an attack of syncope or vomiting. He employed

Cocaine Anæsthesia (*continued*).

cocaine exclusively in cases where the field of operation was not too extensive. He did not use it in abdominal surgery nor in amputations of the limbs; in two cases, however, where he was not able to give *chloroform*, by reason of cardiac trouble, he successfully used *cocaine* in amputating the arm. (*Medical Press and Circular*, May 27, 1896.)

Enuresis.—*Sulphonal*, 6 to 10 grains (0.39 to 0.65 gramme) at night and 2 to 4 grains (0.13 to 0.26 gramme) during the day. (DR. J. MADISON TAYLOR, *Pediatrics*, No. 4, 1896.)

Erosions of the Nipple.—Carefully wash the nipple with 4-per-cent. *boric-acid solution*, after each nursing; apply over it and the entire breast a layer of cotton dipped in the same solution. To keep the cotton humid cover it with gutta-percha cloth. Renew dressing frequently. If it fail, apply *steresol* to the affected part after drawing the lips of the fissure together; ten minutes later apply another coat of *steresol.* In fifteen minutes the child can take the breast, as the *steresol* forms an impermeable varnish. No dressing is necessary. (AUDEBERT, *Arch. de Gyn. et de Tocol.*, May, 1896.)

Gonorrhœal Inflammation.—DR. HERBERT J. HOPKINS, of Pittsburgh, states that, it being granted that gonorrhœa is a self-limited disease, lasting from four to six weeks, and that it is impossible to shorten its course, our endeavor rationally would be to guide the disease to a safe termination, the particular point being to avoid complications and sequelæ, which, he affirms, are frequently due to overzealous pursuance of the popular method of treatment by injections. In the acute forms of gonorrhœa the treatment ought to be a sedative, antiphlogistic, antiseptic one. Rest, physical and especially functional, should as much as possible be secured, and as contributing to this end *bromides* in large and repeated doses should be given. Anything which would tend to excite the sexual organs should be carefully excluded. It is in the urine, nature's self-provided irrigator, that greatest reliance should be placed. Our aim should be to make it abundant, bland, and antiseptic. To accomplish this end, water is to be freely given; the diet, a skimmed-milk one by preference, should at least be free from spices, pastries, and liquors. An *alkaline diuretic* should be prescribed, and if tolerated *cubebs* and *copaiba. Salol* is less irritating and may be substituted. When eliminated through the urine it appears in the form of *carbolic* and *salicylic acids.* Injections as ordinarily used are provocative of more harm than good in the earlier stages, though they are of unquestioned value after the force of the disease has spent itself. The following is recommended by him: ℞ *Cocaine hydrochlor.*, 10 grains (0.65 gramme); *antipyrin*, 6 grains (0.39 gramme); *zinci sulph.*, 6 grains (0.39 gramme); *aquæ rosæ*, ad 3 fluidounces (93 grammes). Sig.: For injection use one-half teaspoonful. Repeat three to six times daily after urinating. Subsequently a more strictly astringent injection is indicated,—*zinc*, *silver*, *alum*, *tannin.* Abortive cases occur in this, as in other diseases; but, as stated before, little good can be expected from measures adopted for this purpose after the disease is established. The infecting virus shortly after exposure can readily be destroyed, however, and the disease thus prevented. (*Medical Record*, May 23, 1896.)

Graves's Disease.—DR. ALLEN STARR treated a case of exophthalmic goitre with *glycerophosphate of sodium* in doses of 20 grains (1.3 grammes) three or four times daily. Improvement began within two weeks, though other medical measures had been unsuccessfully tried for a year and a half. (*Medical News*, April 18, 1896.)

Intubation.—In a case where attempts at extraction caused a small tube to sink farther down into the larynx, TRUMPP made pressure with the thumb on the trachea, just below the cricoid cartilage, where the end of the tube could be felt, causing cough, which forced the tube out. This method of expression never failed in subsequent cases in which he tried it. The pressure may be made with both thumbs inward and directly upward. If a more powerful pressure is exerted the tube may be forced entirely out of the mouth. (*Münch. med. Woch.*, April 28, 1896.)

Phenol in Tetanus.—SBRANA reports a case of tetanus cured by hypodermatic injections of a 2-per-cent. solution of *phenol* into the foot which had been wounded. The injections were made three times a day, and on the seventeenth day the patient was entirely cured. (*Riforma Medica*, March 16, 1896.)

Sanoform.—This new substitute for *iodoform* was introduced by Gallinek and Courant in 1895, and has lately been tried by LÖHNSTEIN in chancre, bubo, phimosis, wounds after the excision of ulcers or abscesses. It is chemically *di-iodo-salicylic acid methyl-ether*, contains 62.7 per cent. of *iodine*, and is odorless and tasteless. Being moderately soluble in *alcohol* and readily soluble in *ether* and *vaselin*, it is suitable for use in medicating *collodion*, *gauze*, or *vaselin*. Löhnstein dusted the pure powder on the surfaces of the wounds and ulcers, and used a 10-per-cent. ointment when suppuration had ceased. The healing power was most marked in chancre. While inferior to *iodoform*, *sanoform* has the advantages of being odorless and non-poisonous. (*Deut. med. Zeit.*, May 14, 1896.)

Sodium Hyposulphite in Diphtheria.—DR. H. A. WICKERS, of London, has for some time been using a solution of *sodium hyposulphite* as a local application in diphtheria and has been well satisfied with the results, three or four applications having generally been sufficient to clear away the false membrane. The solution is prepared for use by mixing equal parts of pure *glycerin* and a saturated solution of *hyposulphite of sodium* in water, and is applied with a brush to the exudation and inflamed fauces once or twice daily or as often as may be deemed necessary. The *glycerin* by its adhesiveness keeps the solution longer in contact, and also by its well-known local action helps to relieve that

Sodium Hyposulphite in Diphtheria (*continued*).

engorgement of the mucous membrane which seems especially favorable to the growth of exudation. It is probable that the *hyposulphite* has a continuing action as a germicide in the following manner: Chemical decomposition is first set up by contact with the acid secretions of the mouth and throat, *sulphur* and *sulphurous acid* in a nascent state being set free; the latter, being gradually converted by oxidation into *sulphuric acid*, would in the same manner decompose further portions of unchanged *hyposulphite*, and so on until the *hyposulphite* was exhausted. Of course, this local treatment will not interfere with the general treatment, which must be adapted to the necessities of each individual case. (*Lancet*, June 6, 1896.)

Vaselin-Spray in Chronic Nasal Inflammation.—Dr. Thomas F. Rumbold, after twenty-three years' experience, asserts, in the *St. Louis Medical and Surgical Journal*, that there is no agent nearly so valuable as a local application to the upper air-passages as *vaselin;* it is the most useful cleanser and antiseptic and the most rapid of all solvents of abnormal nasal secretion, whether in the semifluid or solid form, that has ever been employed. There are no means of making local applications equal to properly-constructed spray-producers whose action is perfectly non-irritating, while most thorough in reaching the unseen surfaces that are almost always diseased. The objects of this treatment are (1) to remove the abnormal secretion from the inflamed mucous membrane and (2) to apply a warm, soothing antiseptic to every portion of the inflamed nasal passages. The treatment should be perfectly painless, and is made by instruments carrying the spray in four different directions and actuated by an air-pressure of from two to eight pounds to the square inch. In all cases, especially in those which there is much muco-purulent discharge, a small quantity—barely enough to taste—of *eucalyptol* is added by him.

☞ Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."

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No. 28, RUE DE MADRID, PARIS, FRANCE.

(End of Editorial Department of Journal for July, 1896.)

ORPHOL.

This name has been given to beta-naphthol bismuth, or a chemically-pure naphtholate of bismuth, free from taste and odor. Orphol is decomposed in the intestinal canal into naphthol and bismuth. It may be given in daily doses of 150 grains, but half that quantity will usually be sufficient. A paper upon the use of Orphol as an intestinal antiseptic and external remedy has recently been published by Dr. Edmond Chaumier, of Tours, France Dr. Chaumier has had excellent results from the administration of Orphol in dilatation of the stomach, chronic gastritis, indigestion, diarrhœa, enteritis, etc. In gastric and intestinal carcinoma it is useful by checking fermentation. Its antiseptic power renders it valuable in gastric ulcer, tubercular gastritis, typhoid fever, dysentery, and tubercular diarrhœa. Disinfection of the bowel by Orphol is also of service in furunculosis, acne, and other affections of the skin dependent upon auto infection. It has relieved the diarrhœa and abdominal pain of hepatic cirrhosis. Orphol may be advantageously applied locally to burns, ulcers, etc.

TRIONAL.

It will generally be conceded that the results obtained by different observers from the use of any given remedy will vary to some extent, according to the method of administration and the selection of cases. These factors must always be taken into consideration in estimating the value of a new remedy. Dr. Drews (*Wiener medic. Presse*, Nos. 13 and 14) has recently afforded striking instances of this in the case of Trional. A man, who had been troubled with sleeplessness for several nights owing to severe pains from a phlegmon of the hand, took 1 5 grammes of Trional dry on the tongue and followed by a drink of Seltzer water. Sleep did not occur until the end of an hour, lasted only three hours, and on the following morning slight after-effects were experienced. After having taken the drug in the same manner for several nights with the same effect a proper mode of administration was adopted, it being given in an abundance of hot fluid (milk and tea). When employed in this manner its action left nothing to be desired; sleep occurred in ten minutes, lasted for eight hours, and on awaking the patient felt greatly refreshed. In the case of a woman, 58 years old, suffering from uterine cancer, Trional also failed to exhibit its full effect until properly administered. These observations lead Drews to emphasize the rules laid down by Dr. Goldmann for the administration of this remedy. These, in brief, are as follow: During continued use of Trional attention should be paid to regular evacuations of the bowels and an abundance of carbonated waters should be taken during the day. It should never be administered in doses above 2.0 grammes, and in all cases where the insomnia is not due to pains 1.5 grammes are usually sufficient to produce sleep of six to eight hours' duration. In neurasthenic insomnia a dose of 1.0 gramme is ordinarily satisfactory. Trional should never be taken dry on the tongue and followed by a swallow of cold water, but always in connection with a cupful of fluid as warm as possible,—as soup, tea, milk, etc. During its prolonged employment its administration should now and then be interrupted. Aside from the use of carbonated waters, it is also advisable, in cases of chronic sleeplessness, to administer salts of the vegetable acids (citrates or tartrates). If these directions are carried out, Trional will prove a very serviceable hypnotic.

THE

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Selections from Society Proceedings.

AUSTRIA.

VIENNA MEDICAL CLUB.

Alterations of the Membrana Tympanum.—PROF. POLITZER gave the results of his personal observations on this subject, stating that the lesions are either primary or secondary, the former being localized in the dermal layer. Sometimes hæmorrhagic vesicles are noted, especially in the course of influenza. Changes similar to those of primary myringitis are also met with in acute otitis media, this latter affection being only distinguished by considerable disturbance of hearing. Primary chronic myringitis is rare and difficult of diagnosis; it is frequently accompanied by granulations of the tympanic membrane, but hearing is not diminished. When granulations are present the membrane retains its motor power, but this is not the case when the drum is involved. Such granulations may be removed by cauterizing with perchloride of iron. In cases of traumatic rupture of the membrane the edges of the wound retract and present hæmorrhagic suffusions.

Secondary alterations of the membrane are due to catarrh or to purulent otitis media. The presence of a serous fluid in the drum is recognized by a characteristic line on the membrane. When a large quantity of fluid has accumulated in the middle ear, the tympanum assumes a yellowish color. This fluid may be evacuated by the Eustachian tube through insufflations, the head being laterally inclined. Catarrh of the middle ear often gives rise to partial or diffuse opacity of the tympanum, due to calcareous deposits. In otitis media the tympanum also shows retraction, this and a grayish coloration being especially marked in catarrh of the Eustachian tube and drum in children. In patients affected with sclerosis of the labyrinthine capsule, the reddish projection may be seen through the tympanum.

It is very important to distinguish catarrh from acute otitis media. In the latter there is great hyperæmia with secretion of the membrana tympani. When there is perforation the edges of the rupture are in juxtaposition and pulsate. In otitis from influenza the tympanum will often be seen to be raised up at its posterior and superior part. In scarlatinal, diphtheritic, or tuberculous inflammations the tympanum disappears.

The lesions of the organ in chronic otitis media are various; sometimes several perforations may be noted, especially in tuberculous patients. Perforations of the tympanum are capable of cicatrization, the cicatrices being either free or adherent to the inner wall of the drum. Sometimes a septum forms between the Eustachian tube and the drum. Perforation of Shrapnell's membrane may be met with in inflammation of the external portion of the attic, and these suppurations resist all treatment, often giving rise to circumscribed caries of the bone.—*Semaine Méd.*, May 27, 1896.

Lupus.—Notwithstanding the commendations of less heroic measures in the treatment of lupus, PROFESSOR LANG holds tenaciously to the excision method of dealing with this disease. The difficulty, he affirms, lies only in the situation of the operation at the orifices of canals where skin and mucous membrane meet, such as the mouth, nose, ear, genitals, or arms. He calls attention to the necessity of decorticating the ear to protect the cartilage from the progressive erosion that accompanies the disease. In such cases a double operation is necessary,—first, the removal of all trace of the disease, and secondly a plastic or cosmetic operation to restore the original appearance. This was well illustrated in one case where repeated attacks on one cheek, involving the nose, and lip below, with dacryocystitis above, had been ingeniously restored by plastic operations.

Deciduoma Malignum.—NEUMANN brought forward a specimen from Schauta's ward, of a deciduous malignant tumor. This affection may be considered as rare, although the malignant formation may take place as a cystic mole after a normal confinement, abortion, or tubular pregnancy. The age of the individual or number of pregnancies have no apparent importance in the formation, but it is evident that profuse hæmorrhage, endometritis, etc., favor the primary morbid changes. The phenomena sometimes occur immediately after the retention of the lochial discharge; in others they may not appear for several weeks. In most cases there is great anæmia, while the tumor can be observed rapidly increasing. Degeneration with metastasis in the lungs, hæmoptysis, and intense cachexia speedily destroy life. The early recognition of this accident is an absolute necessity in the successful treatment. Hæmorrhage, enlargement of the uterus, patency of the cervical canal, and the consistence of the tumor are the clinical points in diagnosis. Microscopical examination of a portion of the tumor may verify the necessity of undertaking an operation of total extirpation of the uterus before metastasis commences. The pathological anatomy of the tumor is described by different observers as varied. Its immediate point of origin appears to be the internal wall of the uterus, forming an irregular substance on its surface which penetrates like polypi into the small structure, forming a succulent, reddish-gray deposit. Sänger first recorded the structural element in

1889, which he considered was developed from the decidua, although many other authors were inclined to view it as a sarcoma arising from the chorion cells.—*Medical Press and Circular*, June 24, 1896.

FRANCE.

Société de Biologie.

The Role of the Spleen in the Defense of the System.—M. Courmont and M. Duffan, of Lyons, communicated the result of their experimental researches on the part taken by the spleen in defending the economy against the attacks of divers microbes. The animal chosen was the rabbit, which supports splenectomy without losing flesh. Injections of the streptococcus pyogenes, staphylococcus pyogenes, and the bacillus pyocyaneus were practiced on these splenectomized animals and on normal rabbits. Rabbits splenectomized from two to twenty-five days beforehand were found to be much more sensitive to the bacillus pyocyaneus than their normal companions, the animal dying in a few hours, whereas normal rabbits survived longer or altogether. The staphylococcus kills the prepared animal in ten hours in a dose insufficient to bring about a like result in the normal rabbit or which kills only in a week. When an attenuated sample of a very virulent culture of streptococcus was injected into the splenectomized rabbit, the animal splenectomized only a few days or hours previously resisted always better than the normal rabbit. The splenectomized rabbit may even survive altogether when the culture is still further weakened. It would thus appear that the spleen, while useful in defending the system against the inroads of the bacillus pyocyaneus and the staphylococcus, is positively mischievous in the struggle against the very virulent or attenuated streptococcus. In both cases a focus of production of phagocytes is suppressed.—*Lancet*, June 27, 1896.

Congrès Français d'Ophtalmologie.

A Study of the Images of Diffusion.—Dr. Bull, of Paris, stated that in order to thoroughly understand what an error of refraction really is the circles of diffusion must be studied. He demonstrated the relation existing between the disturbance of the printed characters seen by the patients and the size of the pupil and the degree of myopia or hypermetropia. He explained how the circles of diffusion deformed the letters on the trial-tables, and advanced the following rule: The diameter of the circles of diffusion is directly proportional to the diameter of the pupil and to the degree of the error of refraction. The size of the circles of diffusion for an errer of 1 D. with a pupil of 4 millimetres being generally 6 millimetres, by means of this rule the form and degree of ocular disturbance can be determined in any patient. Dr. Bull also demonstrated how the circles of diffusion are modified in all eyes by a slight degree of monocular polyopia due to irregularity of the sectors of the crystalline lens.

Comparative Value of Iodine Treatment in Choroiditis.—M. Vignes, of Paris, referred to the communication made by him on this subject at the meeting of 1895. Since then he had treated about 200 patients by the method, and presented the following conclusions: 1. Subcutaneous injections of iodine are more efficacious than any other remedy in effusions of the uveal tract capable of being treated by the iodides. In certain subjects where these were badly borne when given by the mouth, the subcutaneous injections proved curative. 2. The affections of the uveal tract, with or without involvement of the sclerotic, favorably influenced by the iodides are the plastic and fibrinous forms,—viz., disseminated choroiditis, fibrinous irido-choroiditis, and irido-sclero-choroiditis. 3. The injections are especially active in rheumatic choroiditis, and also influence favorably bacillar forms. 4. In specific forms they are no better than the iodides and inferior to mercury. 5. Improvement is evident by the diminution and afterward the disappearance of flakes from the vitreous, finally an increased visual acuity. 6. The method is really efficacious during the exudative period. 7. The daily doses used were 0.01 to 0.04 gramme ($\frac{1}{6}$ to $\frac{5}{8}$ grain), no secondary effects being noted.—*Progrès Médical*, May 16, 1896.

Chronic Glaucoma.—M. ABADIE states that there are two varieties of chronic glaucoma. In one the symptoms are intermittent. The patient says that he sees occasionally iridized circles around flames; vision is dulled and confused for a few hours, and then becomes normal. This form may be advantageously treated by iridectomy, which is, however, useless in the second form, where the progression of the morbid process and symptoms is uniformly slow, silent, and continued, revealing itself only by an increasing loss of sight, corresponding with the proportional elevation of the intra-ocular tension. In this kind of glaucoma, which is perhaps the more common and which affects both eyes consecutively, neither iridectomy nor repeated sclerotomy is of the slightest use, the only benefit accruing being at best a temporary lowering of the tension and a consequent remission. But M. Abadie states that the following treatment is efficacious in this hitherto incurable disease: Commence first with the administration of potassium bromide 1 or 2 grammes ($15\frac{1}{2}$ or 31 grains) and 0.5 gramme ($7\frac{3}{4}$ grains) of sulphate of quinine in daily doses. Locally instill each day 2 drops of a $\frac{1}{2}$-per-cent. solution of eserine. As soon as the tension has become normal leave off gradually the bromide and the quinine, but continue indefinitely the instillations, the solution of eserine being carefully sterilized so as not to irritate the conjunctiva.—*Lancet*, May 30, 1896.

GERMANY.

TWENTY-FIFTH SURGICAL CONGRESS.

Silver as a Surgical Antiseptic.—In a paper on this subject CRÉDÉ stated that the experiments of Holstad and others had proved that solid metals had a bactericide action. A plate of metal placed in a culture is gradually dissolved; gold, which is least powerful against microbes, most slowly, silver and copper much more quickly. The most active metal is thalium, but on account of its toxic properties it cannot be used as an antiseptic; next in efficiency to thallium are silver and cadmium, and then copper, but copper also is too poisonous for practical use. In the solution of silver a lactate of the metal is formed, a salt so very soluble (1 in 15) that it might easily have a poisonous or caustic effect. Of the other eight organic salts of silver the most powerful antiseptic is the citrate, which is very sparingly soluble. But while corrosive sublimate has no antiseptic action in the fluids of animal tissues in a solution weaker than 1 in 20,000, this silver salt is active in a solution of 1 in 80,000. In war and in private practice asepsis is the ideal, but antiseptics are in many cases indispensable. A large number of wounds treated by Crédé by dusting with citrate of silver invariably healed without any reaction. For small wounds he recommends silver-foil, for larger wounds and cavities gauze impregnated with metallic silver, which even after eight days' sojourn in a wound can kill a culture; he has also impregnated sutures and drainage-tubes with the metal. In six cases of erysipelas the temperature fell, and the disease was arrested immediately by the administration hypodermatically in the abdominal walls of small doses of citrate of silver.—*British Medical Journal*, June 20, 1896.

The Murphy Button.—PROFESSOR CZERNY, of Heidelberg, having found that suture of the intestine was a tedious and difficult matter, made experiments on animals to ascertain the practical value of Murphy's button. In three instances reunion of the severed intestine took place immediately without the formation of false membrane, the wound being soon covered with mucous membrane; so that secondary contraction might be excluded. He then used the button in 11 patients, 3 of whom died, 2 of gangrenous hernia; so that their death bore no relation to the operation; the third case, however, died from peritonitis due to perforation, following compression by the button. All the other patients recovered, but in 3 the button had not been passed at the time of report; so that accidents might yet occur. Professor Czerny believed the button to possess many advantages, among others that of hastening and facilitating the reunion of the severed ends of the intestine. The disadvantage consists in the introduction of a foreign body capable of producing disagreeable or even fatal accidents. It is possible that a button capable of being absorbed may yet be found.

PROFESSOR KUMMELL, of Hamburg, believed the Murphy button was not yet as much appreciated by surgeons as it should be. He regarded a two-row suture, well made, as the most perfect operation, but in most cases this requires too long a time, the patients being greatly enfeebled. He had used the Murphy button for the first time in May, 1895, and since then he had used it in a great many cases. The technique is not easy, but the operation is more rapid, the reunion is firm, the patients can at once take food, and stricture rarely follows.—*La Médecine Moderne*, June 20, 1896.

VEREIN FUR INNERE MEDICIN, BERLIN.

Pellotine, a New Hypnotic.—PROFESSOR JOLLY gave an account of a new hypnotic called pellotine, which is not prepared by chemical synthesis like the other sleep-inducing medicaments of the present day, but is an alkaloid discovered in a species of Mexican cactus called anhalonium. The natives of Mexico are reported to swallow slices of this plant, to which they give the name of "pellote," and Dr. Hefter, of Leipzig, has now succeeded in isolating its soporific alkaloid. Pellotine itself is not soluble in water, but its hydrochlorate is extremely soluble. Its physiological action was first tried on frogs and then on mammals, which very soon became unable to stand or perform spontaneous movements, and shortly afterward an increase of the reflexes was observed, followed by tetanic convulsions. This action of the drug on animals was not identical with that which Dr. Hefter observed in himself, for after taking 0.05 gramme ($\frac{3}{4}$ grain) he became very drowsy and ultimately fell asleep. The drug was then given by Professor Jolly to a number of patients in the neurological wards of the Charité Hospital, in Berlin. The first case was that of a man suffering from alcoholic neuritis, who, after an injection of 0.04 gramme ($\frac{5}{8}$ grain), became very drowsy, and one hour afterward fell into a sleep lasting four hours. Dr. Hefter had observed in himself a diminished pulse-rate, and the same symptom was perceptible in this patient, during the first hour of whose sleep the pulse fell to 56 per minute, rising again to 76 before the man awoke. Another patient with multiple sclerosis took 0.05 gramme ($\frac{3}{4}$ grain) during the afternoon, and after half an hour he also slept soundly for several hours. Similar results were obtained in a series of other cases. In patients suffering from tabes the soporific action was equally satisfactory, but the pains returned after they awoke. In delirium tremens the effect was less prompt; in one instance 0.12 gramme ($1\frac{3}{4}$ grains) was needed only to tranquilize an excited patient, but no sleep ensued. In twenty cases of different kinds the remedy was given as an hypnotic in the evening. Two centigrammes had no effect, but from 4 to 6 were efficacious in producing sleep, and no injurious consequences of any kind were observed. Some patients complained of giddiness and declined to take the medicine, but the greater number did not suffer in this way. Professor Jolly says that 0.06 gramme (about 1 grain) of pellotine is equal to 1 gramme ($15\frac{1}{2}$ grains) of trional, or 2 grammes (31 grains) of hydrate of chloral. The number of cases is as yet too small to justify the formation of a definite opinion as to the new remedy, but it undoubtedly deserves further trial.—*Lancet*, June 20, 1896.

GREAT BRITAIN.

British Gynæcological Society.

Psychological Consequences of Suppressed Menstruation.—In a paper on this subject Dr. Fancourt Barnes recalled the fact that the menopause, whether natural or artificial, was liable to be associated with mental disturbance, and that the natural climacteric had a more marked influence in this respect than the sudden inhibition of menstruation by accidental causes. He then briefly reviewed the process of menstruation from the point of view of the variations in vascular tension which it occasioned and which could be demonstrated by the sphygmograph. He believed that the increased vascular tension was in some measure responsible for the mental disturbances found. This was illustrated by the following case: The patient was aged 27 and was single. A year before coming under observation she had a great shock from the death of her father, whereupon menstruation ceased. She became very depressed and weak-minded, while her physical condition deteriorated. She had undergone the routine medical treatment for amenorrhœa; so he advised examination under ether with a view to surgical intervention. Finding the os uteri not well developed, he divided the cervix bilaterally and applied tinctura iodi to the endometrium. A similar application was made twice a week for the next three weeks. A month after the operation menstruation came on freely and painlessly. She at once began to improve mentally and physically, and some months after was perfectly well.

Dr. Leith Napier said he had seen cases such as that recorded in the paper, and thought Dr. Barnes's argument a sound one. He recalled the case of a young girl in whom the sudden suppression of menstruation following on a chill was associated with severe neuralgia and complete blindness. The latter shortly passed off and menstruation was re-established. In another case, after removal of the appendages, the patient menstruated regularly for two and a half years; as the flow then became profuse he curetted the uterus. Menstruation ceased and symptoms of the menopause came on. They were so severe that he ordered an emmenagogue; the flow returned and the symptoms ceased. When she left off taking the medicine amenorrhœa again resulted, with the same symptoms as before.

Dr. Robert Barnes thought the case well illustrated the association between menstruation and the nervous system. In a paper read before the society some years ago he dwelt on the relation of menstruation to insanity. If the present case had got into an asylum she would probably have stayed there, for he regarded it as a great fault in the organization of our asylums that there was no provision for the examination of such cases. Not only should women be examined before being committed to asylums, but the asylum authorities should employ skilled gynæcologists to attend to pelvic disease occurring among the inmates, whether or not the mental condition was likely to be benefited thereby. As it was he regarded asylum medical officers as among the most absolute of the profession, and once a woman was placed in an asylum she was likely to stay there.

Dr. Routh had seen a great number of these cases where the neurotic condition was so marked that unless the patients were in good hands they were very likely to drift into an asylum. As a rule, no one knew less of the gynæcological conditions in the insane than the medical attendants in asylums; more than once he had been called in to see patients, and had been able to save some of them from spending their days as lunatics. Dr. Barnes's paper would have done much, if it did nothing else but call attention to the fact that many kinds of insanity were due to suppression of the menses.

Dr. Macnaughton Jones said they must remember that suppression of the menses was sometimes the result, and not the cause, of mental disturbance. They should not too broadly impeach the heads of asylums, and some of the remarks made by previous speakers on this point were not just.

He knew personally many asylum medical officers, and was convinced that they were just as alive to the co-ordination of mental and sexual conditions as any one present, and were just as anxious to arrive at the truth of the matter and secure the well-being of the patients. The question of treatment was often very difficult, for the patient's safety had to be thought of, and it was sometimes necessary to put her under temporary restraint. He remembered a case in which a young girl walked into the river while under treatment for the restoration of her menstrual functions. Dr. Barnes's remarks about the variations in vascular tension were interesting; the high tension might show itself in other directions, as in disturbances of the eyes, ears, nose, or throat.

Dr. Fancourt Barnes, in reply, said his object had been to show the value of surgical methods in some cases which were generally looked on as purely medical. The case was, no doubt, an extreme one, and of course they would not wish, as a rule, to resort to surgical measures in the case of young girls. He had had good results from similar treatment in cases of dysmenorrhœa.—*Lancet*, June 27, 1896.

Laryngological Society of London.

Obstruction of the Larynx by a Web.—Dr. Barclay Baron, of Bristol, described the case of a man, aged 39 years, who had not had syphilis nor other constitutional dyscrasia. In October, 1894, he had hoarseness and loss of voice with gradually-increasing difficulty of breathing, which induced his own doctor to perform laryngotomy. On being admitted into the Bristol General Hospital under Mr. Baron, there was found to be intense inflammation of the whole of the larynx; the vocal cords, which were in apposition, were especially affected, being intensely red, swollen, and motionless. In spite of all that was done he continued in this condition for three months. Tracheotomy was then performed and the laryngotomy tube removed. The effect of this was soon beneficial,—first one vocal cord and then the other leaving the middle line, and then the anterior two-thirds of the vocal cords was found to be united by a web. This was cut by Whistler's cutting dilator, and dilated by Schrötter's and other bougies, and now only a small amount of web-tissue uniting the under surface of the vocal cords in front persists. The tracheotomy tube has been removed, and the man is able to do his work as a farm-laborer.

Thyrotomy for Epithelioma of the Larynx.—Dr. Felix Semon related a case of this kind. The patient, a man aged 65, was first seen on February 18th of this year. The only symptom was hoarseness dating back nearly a year and a half, and supposed to have commenced after an attack of influenza, which had also caused purulent discharge from the right nostril; this, however, troubled the patient very little. The whole of the left vocal cord, particularly in its middle part, was considerably tumefied, and showed a granular appearance. At the same time its mobility was surprisingly free and the hoarseness, comparatively speaking, very slight. Malignant disease had already been diagnosed by Dr. Madden and Mr. Dudley

Wright. The diagnosis was further corroborated by Mr. Butlin. The operation was performed on February 27, and offered no incidents of importance. On opening the larynx the growth was seen to extend all over the left vocal cord, and the ventricular band also appeared somewhat swollen. In front the growth just extended to the median line. The whole affected portion was delineated by two semicircular cuts at a distance of about three-fourths of an inch from the growth, meeting in front and behind and cut out with curved scissors. Posteriorly the extirpation extended to the front part of the arytenoid cartilage, which was also removed. The patient made an excellent recovery, except that on the third day some ominous black spots appeared in the wound, supposed to be due to infection from the purulent nasal discharge. These were scraped out, and nothing further occurred.

Healed Tuberculous Disease of the Larynx.—A case of this kind was shown by Mr. Lambert Lack. The patient, a girl aged 28, was quite well until 1893, when symptoms of phthisis developed and she lost her voice. In October, 1893, the patient was losing flesh, had much cough and a hectic look. She was nearly aphonic. Examination of lungs showed dullness over the upper half of the chest on both sides, back and front, with abundant moist sounds and bronchial breathing at the right apex. Examination of larynx showed irregular fleshy thickening of both vocal cords, with very deficient movement on the right side. There was a prominent ulcerating growth on the anterior surface of the right arytenoid and some œdema of both arytenoids. Treatment: Codliver-oil and iron internally and pure lactic acid well rubbed in locally once a week. After some months' rather irregular attendance she was much improved, but the tumor remained much the same. This was then entirely scraped away with the curette and pure chromic acid applied to the resulting ulcer. This slowly healed, and in the spring of 1895 the ulcer of the larynx was quite healed. In November the larynx appeared almost normal, the movements being quite free, and there was no trace of swelling or ulceration.

Uncontrollable, Intermittent, Laryngeal Cry.—Dr. Bond described the case of a boy, aged 11, who began in March, 1895, one night when in bed, to utter at irregular intervals a loud cry. This he continued to do until August, 1895, when he went to stay for about ten days in the country, and toward the end of the visit the cry "gradually" ceased. At Christmas, 1895, a second attack came on at 3 A.M., and had continued since. He appeared to be dull and stupid, with hands and arms continually working like those of a child with chorea. At intervals, varying from about twelve seconds to one and one-half minutes, he utters an explosive, sudden cry of considerable volume, very like part of a milkman's cry, but not resembling any word. The cry is associated with somewhat violent action of the diaphragm and with a lifting of the soft palate. It is never emitted during a laryngoscopical examination, but directly afterward. The boy has double proptosis and adenoids of the naso-pharynx. Dr. Bond thought that the removal of adenoids (which would remove a source of irritation and insure sounder sleep), in conjunction with the administration of arsenic and a prolonged change of air in the country, would be the only treatment likely to improve the patient.—*Medical Press and Circular*, June 24, 1896.

LONDON OPHTHALMOLOGICAL SOCIETY.

Vision and Retinal Perception.—In the Bowman Lecture before the Society, DR. H. SNELLEN, Professor of Ophthalmology in the University of Utrecht, described some investigations which he had recently made on vision and retinal perception. Alluding to the contention of Vierordt and others, that it was better to express the acuity of vision by the square of the diameter of the retinal image rather than by its linear measurement, Dr. Snellen pointed out that, while the recognition of form depends on more complicated considerations than can be expressed by the simple linear measure, yet the value of perception is not fully represented by the square measure of the retinal image, inasmuch as the perceptivity of the fovea is not equal all over, but diminishes from the centre outward. Moreover, the act of vision was not confined to the perception of a stationary retinal image, because the movements of the eye brought every part of the image over the centre of the fovea, and each muscular movement represented a linear measure. One of the most important questions was the dependence of acuteness of vision on the amount of illumination and the difficulty of stating the amount of illumination, especially by daylight, which varies so constantly. A fresh series of observations had been recently made on this subject at Utrecht under Dr. Snellen's direction. The observations were carried out by the light of a gas-flame kept at a constant pressure by a special regulator, and passed over benzin to secure constancy of illuminating power. The photometer of Leonhard Weber was used, by means of which it was possible to estimate the amount of light on any given surface without regard to the source of the light. It was found that when the illumination reached a certain degree of intensity the unprotected eye was unconscious of any further increase of luminosity; the maximum of vision was reached with a luminosity of 30- to 50-metre candles. With decrease of illumination the vision soon diminished and changes in intensity were quickly perceived. The acuteness of binocular vision was higher with every degree of illumination than that of monocular vision, but the difference was not equal to doubling the intensity of the light, as had been stated. A further series of observations was made with the photometer in order to arrive at the intensity of daylight at different times in various workshops. In a printing business the want of light impeded the work of compositors when it fell below 15-metre candles, and if at dusk the intensity did not fall below 15-metre candles there would be in full daylight an intensity of 30- to 50-metre candles, direct sunlight being excluded; for coarser kinds of work, like that of carpenters and blacksmiths, a minimum of 10-metre candles was enough. In the new Ophthalmic Hospital at Utrecht special arrangements for lighting the operating-room had been made; the highest demands on the visual powers were made where operations on the eye had to be performed. Considering that the visual power is heightened by adaptation of the eye for a weaker light than that falling on the observed object, the walls, ceiling, and floor of the operating-room had been painted black, and light was only admitted through a window directly on to the patient. By this means the operator had at his disposal the maximum of his vision; there was the additional advantage that the troublesome reflections from the cornea were avoided, and the patient's gaze could be kept fixed in any direction by the flame of a candle, which could be well seen against the dark backgound of the walls. The adaptation of the eye to light was next considered. Like the size of the pupil, the sensibility of the retina changed under the influence of light and darkness. The time required for adaptation corresponds with the period of anatomical changes in the retina,—namely, the formation and disappearance of the visual purple, the changes in the pigment-cells and cones. Observations were made with a small screen, illuminated by an electric spark of great intensity. The moment the light flashed forth there appeared on the screen a bright flood of light, which rapidly increased in intensity and then faded away in about a corresponding period of time. During the increase in intensity the light had the same color as the screen; during the decrease it had the opposite color. This occurred with all colors, provided they were sufficiently saturated. Mixed colors were seen as such, followed during the decrease by opposite mixed colors. It was found that absolute white is very rare; white paper has always a yellow or a blue tint, and dead black appears as saturated blue followed by yellow. These two phases were succeeded by a third phase of much longer duration. The after-image corresponding to this third phase was very feebly colored, and was mostly of a reddish-brown color. As long as this red-brown after-image persisted there was anæsthesia for objective light, such as was given by a plate of luminous paint. The third phase corresponds to the more commonly studied after-images, which arise by long-continued looking at a bright object and its projection on a white surface. This interesting succession of light and dark of the after-image can also be seen on looking at a very feeble light in a darkened room; if this be done the light slowly fades and disappears altogether, but with the slightest movement of the eye it suddenly re-appears, owing to its falling on a fresh part of the retina. If the light be looked at when movement of the eye is carefully avoided after disappearance, it slowly and gradually returns to its former brightness and then slowly fades again, so that a continual slow succession of light and darkness can be observed. These phenomena are to be looked upon as an example of the reciprocal effect of the adjoining parts of the retina on each other; according to Herring's theory of color-vision there is a continuous reciprocal influence between the spot in the retina where the image is observed and the adjoining parts, due to a modification of the visual substance, which undergoes alternate assimilation and dissimilation. Assimilation and dissimilation can temporarily become equally great, and by reciprocal influence neutralize each other.—*Lancet*, June 27, 1896.

UNITED STATES.

New York County Medical Society.

Therapeutics of Heart Disease.—Dr. William H. Thomson said that in no other class of affections was the etiology of so much importance in connection with therapeutics as in diseases of the heart. In the first place, the progressive nature of rheumatic heart diseases should be noted. The rule is that, the younger the patient, the more surely inclined is a slight initial cardiac lesion to develop into a serious structural alteration. The inflammation is more apt to recur in the heart for several reasons. One of these is the formation on the edges of the valves, as a result of the initial endocarditis, of a line of granulations which, by irritation, leads to deeper lesions. The heart is more liable to inflame than at the first attack. The functional activity of the organ is another reason for the liability of the inflammation to recur or progress. These reasons naturally suggest the importance of instituting prophylaxis in rheumatism. The prompt use of the salicylates internally and the local application of tincture of iodine to the throat at the first appearance of the tonsillitis the author considered an important prophylactic measure. It was an undoubted fact that rheumatism prevails chiefly in localities in which persons are most apt to become chilled when the surface of the body is wet. Rheumatic individuals, therefore, should always protect the skin with flannels, both by day and night. The pulse of rheumatic persons should be frequently tested, as it often furnishes valuable advance information regarding an outbreak of some cardiac affection. The speaker assigned to rest in bed the very first place in the therapeutics of heart affections. In many acute cases, however, it did not suffice to bring down the pulse, and in such cases aconite would be found a most valuable drug, for it often relieved the dyspnœa and diminished the frequency of the heart's action. Aconite was not only a cardiac sedative, but it had a decided effect in relieving inflammatory pain. In common with other vegetable nervines it produced no permanent effect on the heart, any more than did tobacco. To give digitalis to a patient with pericarditis and adhesions to the pleura, sternum, and ribs would ordinarily only increase his sufferings, whereás strapping the chest would prove of signal benefit. For the dyspnœa of mitral stenosis he had found belladonna, either with or without sulphuric ether, of great benefit. Its characteristic action was to restore the rhythmical action of unstriped muscular fibre. In cases of mitral stenosis he had often found digitalis inferior to strophanthus, sparteine, and belladonna. In all cases of chronic heart disease the evil effects of anæmia should be borne in mind. Although iron was valuable in many forms of heart disease, he had come to look upon it as decidedly mischievous in rheumatic cases. In all febrile anæmias, such as phthisis, rheumatism, and pernicious anæmia, iron was as likely to do harm as good. For rheumatic anæmia, codliver-oil, with an occasional addition of arsenic, seemed to be the best treatment. The sulphide of calcium, in doses of $\frac{1}{2}$ grain (0.03 gramme) and upward, four times a day, was also useful in these cases.

In the secondary cases of heart disease it should be remembered that the heart is only a part of the circulatory apparatus, and that therefore the disorders of the circulation would affect the heart. Secondary affections of the heart began chiefly at the periphery of the circulation, so that the heart at first underwent hypertrophy and subsequently degeneration and dilatation. In this late stage the chief object of treatment should be to keep up the strength of the walls of the heart. The remedial measures might be divided into the constitutional and the symptomatic. Under the first head a permanent place should be accorded to fresh air. Next to this the author placed properly-applied massage, with properly-regulated muscular resistance by the patient to the movements of the operator. After a few weeks of such massage the improvement in the breathing was so marked that its relation to the treatment could not be doubted. Dilatation of the right side of the heart with dropsy, due to chronic bronchitis, was one of the most curable of heart affections, provided one could cure the bronchitis. The trouble was that a vicious circle was set up. Hours spent in a dry, equable air strengthened the heart-muscle. Among medicines the tincture of the chloride of iron with strychnine did more good than the usual cough-mixtures. The most common, as well as the most serious, of secondary heart diseases were those dependent upon general arterial disease. Long ago it had been very truly said that a " man is as old as his arteries." In secondary dilatation the rapid pulse was not due to irritation of the heart itself, but to the heart not being capable of emptying itself with each stroke. Here digitalis, and not aconite, would lessen this symptom.

In conclusion, the author referred to the use of some of the symptomatic remedies. In secondary cardiac dilatation digitalis took the lead of all other drugs, but there was not one in the list whose administration should be less a matter of routine. By the addition of nitroglycerin we were now enabled to ease the heart of the increased peripheral resistance produced by the digitalis. Another serious effect of digitalis was that when given too continuously or in too large doses it caused gastric disturbance which is very difficult to allay. When using large doses of digitalis, calomel, given in doses of $\frac{1}{2}$ to $\frac{2}{3}$ grain (0.03 to 0.04 gramme) three times a day up to the first signs of mercurialization, often most markedly aided the action of the digitalis. For cases of aortic regurgitation and mitral stenosis he had found serviceable a mixture of tincture of strophanthus, tincture of nux vomica, and tincture of digitalis, equal parts, when given in doses of 20 to 30 drops three times a day. In chronic interstitial nephritis with high-tension pulse and low-specific-gravity urine, small doses of corrosive sublimate seemed to him to be beneficial. He had repeatedly seen cardiac dropsy decline on ordering restriction of the fluids in the diet; hence, milk diet was not appropriate under such circumstances. It should not be forgotten that opium is a most valuable heart stimulant for occasional use. In very many nocturnal attacks of cardiac dyspnœa, chloral proved to be more effective than almost anything else.

Dr. William H. McEnroe, speaking of secondary cardiac disease, referred to the varieties of cardiac failure. One variety was due to overexertion of the heart, another to deficient innervation of the heart. A heart that could refrain from beating rapidly under great excitement or exertion was generally a strong heart. His experience had been that, as a rule, better results were obtained from combining the heart tonics. By combining strophanthus, digitalis, and nitroglycerin we got all the good effects of these drugs without their bad effects. The best remedy for attacks of true angina pectoris, in his opinion, was nitrite of amyl, freely inhaled. For cardiac dyspnœa and cardiac insomnia he knew of no better drug than some preparation of opium.

Dr. S. H. Dessau said that, after the acute stage of pericarditis or endocarditis, he had found that codliver-oil was one of the best remedies. In these cases he felt sure that digitalis could only do harm.

Dr. Henry Dwight Chapin said that many cases of mitral disease appeared to begin in childhood, although no symptoms may have developed for many years afterward. He was of the opinion that we should carefully watch not only children suffering from rheumatism, but those affected with chorea, and thus endeavor to protect them from the dangers of an acute cardiac lesion. As soon as the heart was found to be affected in these cases, prolonged rest should be insisted on.

Dr. Baruch confirmed Dr. Thomson's opinion as to the value of the Swedish movements in heart disease, when systematically carried out under medical supervision.—*American Medico-Surgical Bulletin*, June 6, 1896.

American Laryngological Association, Pittsburgh.

The Sequelæ of Syphilis.—Dr. C. H. Knight, of New York, opened a discussion upon this subject, stating that the diagnosis of late nasal syphilis is not always easy. It may be mistaken for sarcoma and excision of the jaw needlessly advised. The severity of symptoms varies according as the soft parts alone, or, in addition, the hard parts, are involved. Specific disease is not by any means responsible for all septal perforations.

Where the bones are affected we must decide (1) when and how to remove dead bone, and (2) how to correct resulting deformity. He pleaded for conservatism in dealing with sequestra, unless accessible and quite separated. Where dead bone is firmly attached or imbedded—or where we are uncertain as to its extent, or, again, where it is high up in the nares—we must act cautiously. Large masses, if loose and hard, can be removed by the Rouge incision.

For the deformities resulting from bone affections he advocated the Martin platinum bridge. This method is an excellent one if certain precautions are followed. All active symptoms of the disease must have been long quiescent. Radical treatment must have been followed up. The bridge itself must be so fashioned as to avoid friction and pressure. The dissection of the soft parts must be ample enough to avoid tension when once the device has been placed in position. Some cases may be treated by slipping a platinum plate under the skin of the dorsum of the nose, a bed therefor having been made by intra-nasal dissection. This plan is suitable for moderate deformities.

J. E. Nichols, of New York, spoke upon the question as affecting the pharynx. Syphilitic destruction of the uvula or tonsils was not of great importance, but perforation of the soft palate is quite another thing. Destruction of the epiglottis may give rise to no trouble. Adhesions of the pharyngeal wall to the inferior faucial pillars may cause difficulty of articulation and interfere with lingual movements.

In adhesion of the soft palate to the pharyngeal wall the use of caustics should carefully be avoided, as they increase adhesion. Potassic iodide should be regularly given. The symptoms of adhesion are: impaired voice, mouth-breathing, traction on the orifices of the Eustachian tubes, causing aural complications, even otitis media, anosmia, and accumulation of mucopus in the pharynx.

The cautery and knife have both been employed in the treatment of these cases, with subsequent digital or instrumental dilatation. There is always great liability to a return of the deformity. Dr. Nichols described the operation devised several years ago by him for the relief of adhesions between the soft palate and the pharyngeal wall.

Dr. W. K. Simpson considered the question as related to the larynx. The word "sequelæ" had a somewhat peculiar significance as applied to syphilis. In this disease what we call sequelæ are in reality the later manifestations of the disease, occurring in regular order unless prevented by treatment We may have (1) acute exacerbations coming on in long-continued tertiary cases; (2) active tertiary outbreaks with structural changes still going on; (3) syphilitic lesions on other parts of the body, with chronic laryngeal hyperæmia, possible thickening, retained secretion, and hoarseness from overuse of the parts; and (4) changes which are excited by climate and occupation.

In laryngeal obstruction occurring suddenly in the adult, we may find a smooth, uniform swelling, which covers a gumma, a perichondritis, or a subglottic stenosis. In many of these cases intra-laryngeal injections directly into the substance of the tissues may effect good results. Tracheotomy may be necessary in threatening cases. Dilatation is a procedure of great value, and can best be done by intubation. The constant pressure of the tube produces absorption, and may wear out the tendency to recurrence of the stenosis.

Dr. John O. Roe had found the most serious nasal conditions in children with hereditary syphilis. The entire septum and even nasal bones may be destroyed. In adults, abscess of the septum frequently results, leading to destruction of the sesamoid cartilages. He was accustomed to repair these cases by a subcutaneous flap operation.

Dr. Roaldes believed that nearly all the advantages of the Rouge operation could be obtained by intra-nasal perforation of the sequestrum by drilling and crushing with the forceps.

Dr. Ingals had found syphilitic ulcerations of the cartilage rare, unless the bony septum was also involved. From 5 to 10 per cent. of perforations were probably syphilitic.

Dr. Porcher spoke of the nasal appearance in leprosy. He advocated in syphilis the use of mercury controlled by minute doses of opium.

Dr. Hubbard believed that mercury is apt to cause increased destruction of cancellous tissue unless we can keep the parts affected perfectly free.

Dr. Delavan called attention to the risk of primary and secondary hæmorrhage after operations in these cases.

Squamous Epithelioma of the Soft Palate Cured by Injections of Caustic Potash.—Dr. T. Hubbard related the case of a male patient who had had for over a year a flattened mass partly in the soft palate and partly in the anterior faucial pillar of the left side. All internal and local treatment had been useless. Cocaine was used to relieve pain in swallowing, and the cocaine habit had been established. The bodily prostration was extreme. Only milk and ice-cream in small quantities could be taken. The cocaine habit was first broken up, and then, through a curved platinum needle, caustic-potash injections were made, destroying a conical-shaped mass of the growth. Injections were repeated on the re-appearance of any proliferating epithelium around the edges of the mass. Rapid cicatrization and improvement in general health followed, the patient gaining 40 pounds (18 kilogrammes) in two months. No recurrence had taken place at the time of report, two years later.

Sarcoma of the Nasal Chambers and Accessory Sinuses.—Dr. A. A. Bliss, of Philadelphia, reported two cases of this kind. The first patient was a child, aged 4, with the left nostril obstructed by polypi since the first year of age. These were removed, but recurred in six days. In the next eight months over thirty such removals had been done. When first seen by Dr. Bliss the left nostril was occluded, the septum was pushed over to the right, and the left eyeball protruded, but there was no glandular enlargement. The antrum was opened and found full of a fungoid mass, which was cleaned out. Considerable hæmorrhage followed, and was checked by gauze plugging. No recurrence of growth took place, but in six weeks glands under the jaw became involved and symptoms of cerebral and respiratory disturbance developed, death taking place six weeks later. The second patient was 9 years of age, and suffered from occlusion of the left naris, enlarged cervical glands, and exophthalmos. He was said to have been well up to three weeks before he was seen by Dr. Bliss. His bad general condition precluded any operation.—*American Medico-Surgical Bulletin*, May 30, 1896.

Boston Society for Medical Improvement.

Chlorosis, with Especial Reference to its Treatment by Intestinal Antiseptics.—Dr. Charles W. Townsend gave the results of his experience during his last year's service in the out-patient department of the Massachusetts General Hospital, with this method of treating chlorosis, as advanced by Forscheimer in 1893.

In order to make sure of the diagnoses, the blood-corpuscles were counted at least once in each case, and the hæmoglobin was estimated at each visit, by means of the Fleischl hæmometer and Zeiss blood-counter.

The average percentage of hæmoglobin in the 87 cases of chlorosis studied was 35.5 per cent., the extremes being 18 and 72 per cent. The youngest patient was 15, the oldest 34 years; 70 per cent. were between 16 and 20 years of age, 20 per cent. between 21 and 25 years. Sixty-three per cent. were born in the United States; 19 per cent. were Irish; 12 per cent. from the Provinces; 1 was colored. Twenty per cent. of the immigrants became chlorotic within a year of their arrival here, and more than half of these came from the Provinces. This is a familiar fact, and is commonly explained by a change of manner of living from out-of-doors to the confined work of domestic servants. This, however, cannot explain the effect in all cases, for the author has known nursery maids, who spent a larger part of their time in the opin air and who led very hygienic lives, to become chlorotic within a short time of their emigration from the Provinces. The climatic change seems to be the underlying cause. The duration of the disease was under six months in 70 per cent. of the cases, while 15 per cent. had suffered from six months to one year and another 15 per cent. had suffered over a year. The most common symptom was palpitation, all the patients complaining of this, generally on the slightest exertion. All but 3 complained also of dyspnœa on exertion. Seventy-four per cent. complained of headache, 75 per cent. of dyspepsia, 65 per cent. of constipation, leaving 35 per cent. where the bowels were regular.

In 54 per cent. menstruation was scanty, in many of these being also irregular. In 15 per cent. it was normal, in 11 per cent. it was profuse, and in 20 per cent. there was amenorrhœa in periods of two months to a year. In 2 of these menstruation had never occurred. Œdema, usually confined to the legs, but sometimes more general, was said to occur in 34 per cent. of the cases.

Dr. Townsend gave the following

TABLE OF COLOR IN PERCENTAGES.

	Pale.	Fair.	Good.
Nails,	95	5	0
Cheeks,	89	7	4
Tongue,	84	15	1.2
Lips,	76	21	2.4
Conjunctivæ,	64	25.5	10.5

He was surprised at this last result, as he had formerly considered the color of the conjunctivæ of special value in diagnosis. The color of the nails varies somewhat with the method of examination. When the fingers are fully extended, as is usually the case when the patient presents them for inspection, the circulation under the nails appears to be partly cut off, and the middle or sometimes proximal half of the nail becomes white. This occurred, especially by hyperextension of the fingers, even among the plethoric, but was much less marked, as a rule, than in the anæmic. By examining the fingers partly flexed this error could be avoided. Besides the color of the tongue, the flabby and often-indented appearance was generally present. Marked indentation from the teeth was noted in 34 per cent. of the cases, which is much understating its frequency, as this condition was recorded in the latter half of the cases only.

The *bruit de diable* was present in 86 per cent. of the cases, being heard in a little more than half of these, or in 45 per cent. of all the cases, in both sides of the neck. In about 15 per cent. of all the cases a bruit was heard in the left side of the neck alone, and in 25 per cent. of the cases on the right side alone. As regards the systolic murmur at the base of the heart this was present in 50 per cent. of all the cases; but in 9 of these it could be heard only after increasing the heart-beat by exertion, the patient being made to walk across the floor several times. In a few cases the disappearance of the bruit or murmur was noticed; thus the systolic murmur disappeared in 1 case when the hæmoglobin reached 63 per cent. and in 2 cases 68 per cent., the hæmoglobin before treatment being, respectively, 23, 28, and 28 per cent. A bruit heard at the left alone at 50 per cent. disappeared at 75 per cent. Bruits heard at both sides at 40 and 38 per cent. disappeared from the right at 55 per cent. in one of the cases, and from the left at 76 per cent. in the other.

As out-patients these cases continued in their former life, modified but slightly by directions given as to diet, etc.; so that the results of treatment should not be compared with those obtained inside a hospital.

There were 30 cases which could be carefully followed who were treated with beta-naphthol without iron for purposes of intestinal antisepsis. Two grains were given three times daily, and the average length of treatment was three and one-third weeks. The average gain in hæmoglobin per week in these cases was a little less than 2 (1.85) per cent., the greatest gain being 10 per cent. per week for two weeks and 6 per cent. for five weeks. The patient that did the worst lost 7.50 per cent. per week for two weeks. After three weeks of beta-naphthol treatment, if the patient gained less than 2 per cent. of hæmoglobin a week she was put on Blaud's iron pills.

There were 31 cases treated with Blaud's pills, 5 grains (0.32 gramme) only, t. i. d., for an average length of four weeks. The average gain per week was a fraction over 5 per cent. (5.07), or more than two and one-half times as much as in the case of beta-naphthol. In Dr. Stone's cases, treated in the same clinic with Blaud's pills, a gain of 5 per cent. per week is stated to be a fair average.

As so many cases were constipated (65 per cent.), although less than are generally supposed, and as this symptom was always treated with cascara, whether the patient was given beta-naphthol or iron, it seemed to the author of interest to treat a series of these constipated cases with cascara alone. Seven cases were so treated; to some of these nux vomica and hydrochloric acid being also given where the stomach was also disordered. The results, however, were not encouraging, as these cases, after treatment averaging two weeks and one day, lost on an average $1\frac{1}{2}$ per cent. of hæmoglobin a week. The greatest gain made was but 4 per cent. in one case. These results, as well as the 35 per cent. of the cases of chlorosis without constipation, do not bear out Sir Andrew Clark's deduction that chlorosis is largely dependent on constipation.

Of the 31 cases treated with iron, 12 had previously had a preliminary treatment for three weeks with beta-naphthol with an average loss of $\frac{1}{12}$ per cent. per week. When put on iron these gained 6.7 per cent. per week for an average of four and two-thirds weeks. This certainly shows the superiority of the iron treatment in these cases and seems also to point to a certain advantage from the preliminary treatment with beta-naphthol; for of

19 cases treated with iron without the preliminary beta-naphthol treatment the average gain for three and one-half weeks was 4.5 per cent. per week. A simple computation will show, however, that at the end of seven weeks the last set of cases continuing the slower gain would be ahead of the other cases with the two sets of treatment. Further experience shows the results of the combined treatment to be considerably better than those obtained with iron alone, and much better than those with beta-naphthol alone. —*Boston Medical and Surgical Journal*, May 28, 1896.

New York Academy of Medicine.

New Remedies in the Treatment of Diseases of the Upper Air-Passages. —Dr. Carl E. Munger stated that during the past year a number of so-called new remedies had been used in the Manhattan Eye and Ear Hospital in the treatment of nasal and laryngeal diseases, and his report was based on the record of clinical cases at Dr. Chappell's clinic during the past year. Some of the drugs were but old ones dressed in new clothes, some had proven useful, and some had not.

Argentamin was of much value in the treatment of catarrhal and purulent rhinitis, a 5- to 10-per-cent. solution being applied to the well-cleansed mucous membrane by the physician not oftener than every second day. A ½- to 2-per-cent. solution might be given the patient for daily use at home. The older silver salts seemed better in chronic laryngitis.

Acetanilid was used for insufflation on nasal wounds after operations. The pure powder proved a better dressing than when mixed with zinc stearate. The healing seemed more rapid; frontal headache and neuralgic pains following operations seemed less frequent; and no cyanosis, profuse sweating, cardiac depression, or unfavorable systemic effects were observed. Persistent hæmorrhages were apt to follow the use of the drug upon septal wounds.

Tannigen was used in cases of hypertrophic rhinitis and chronic nasal pharyngitis. The physician can use an alcoholic solution of 1 drachm (4 grammes) to the ounce (31 grammes), while for the patients' use it was given from 10 grains to 1 drachm (0.65 to 4 grammes) to the ounce (31 grammes) in a vehicle known at the hospital as "Oleum Hydrocarbon Compound." This was proposed by Dr. W. F. Chappell, and is a mixture of unguentum zinci oxidi and benzoinol, a few drops of oleum gaultheriæ and oleum sassafras. The pure drug proved to be too strong; sometimes the solution was made weaker than the above, but it did not prove as satisfactory in its results as was hoped, and seemed to act as a stimulant rather than an astringent.

Formalin in ½- to 2-per-cent. solution was an effective deodorizer and disinfectant, and especially useful in syphilitic ulcerations.

Creasote carbonate gave good results in acute follicular tonsillitis, even without other local or constitutional treatment. It relieved the patient quite rapidly and often cured the case in two or three days.

Pyrozone was used in a 3- and a 25-per-cent. solution. The 3-per-cent. solution was valuable as an antiseptic and hæmostatic after operations, as a deodorizer, and to soften crusts and scabs previous to removal. The 25-per-cent. solution, called "caustic pyrozone," was used in follicular pharyngitis and tonsillitis with fair results. It seemed more useful in a few cases of pharyngitis literalis and mycosis of the pharynx.

Lysol had not been much used. In ½- to 2-per cent. solution it seemed a good antiseptic spray in cases where it was the custom to use carbolic-acid solutions. It frequently proved very irritating to the mucous membrane, and its use was discontinued.

Thiol had not proved useful as yet. Absence of staining properties and disagreeable odors made it more pleasant for intra-nasal use than ichthyol.

Ortho-mono-chlorphenol had been used extensively in atrophic and ulcerative rhinitis and eczema alæ nasi, and the secretion and crusts were lessened very promptly by its use, and excoriations healed kindly. A 25-per-cent. solution in glycerin was used, but the speaker noted that this 25-per-cent. solution should be used by the physician only and made as frequently as necessity demands. The drug was useful in ulcerations on the septum or turbinated bones, and in atrophic rhinitis most brilliant results were obtained. It was also useful in chronic naso-pharyngitis where the post-nasal secretion was excessive.

Dr. T. P. Berens said he had used ortho-chlorphenol since 1884. He called attention to its anæsthetic effect and said it numbed the base of the tongue when applied for irritation. He had found it useful in ethmoidal disease, where frequent application of the pure drug upon a very small tampon to polypoid or beginning polypoid degeneration gave good results.

Dr. Gleitsmann said he had been using mono-chlorphenol, and had not found that it possessed any anæsthetic properties. He used it in a 2½-per-cent. solution. He called attention once more to the anæsthetic property of antipyrin. In acute tonsillitis he injected 2 to 5 drops of a 50-per-cent. solution, with the desired effect.

Dr. Newcomb said that a 5-per-cent. solution of guaiacol upon a pledget of cotton applied to the nose caused complete anæsthesia, and could be used in the ear when performing paracentesis of the drum-membrane.—*American Medico-Surgical Bulletin*, May 16, 1896.

Hay Fever.—In a typical case of hay fever, Dr. Abercrombie, of London, tried the following plan of treatment: 1. *Valerianate-of-zinc pills*, 3 grains (0.2 gramme) in each; one pill to be taken three times a day after meals; to be commenced a full month before the onset of the attack was expected, and to be continued for at least a month after the usual time of onset. 2. As local palliative measures, if required: (*a*) a 5-per-cent. watery solution of *hydrochlorate of cocaine*, to be used as a spray to the nose and throat; and (*b*) a snuff composed of *bismuth*, *morphine*, etc. For three successive years the patient has used the *valerianate of zinc*, and has had no return of the attacks. (*British Medical Journal*, April 18, 1896.)

Selections from Reports of Members of the Annual's Staff of Correspondents.

Italia.

PROF. F. MASSEI,
REDATTORE CORRISPONDENTE PER LE LARINGOLOGIA E RINOLOGIA.

Si prega di mandare tutti i giornali, libri, stampe, etc., sulle suggetti sopra nominate che vedono la luce in Italia al

PROF. F. MASSEI,
4, Piazza Municipio,
Napoli.

Diagnosis and Treatment of Laryngeal Tuberculosis.—In a lecture, given at the second meeting of the Italian Laryngological Association, in Florence, MASSEI pointed out the interest of some cases of laryngeal tuberculosis not easily recognized, since they resemble a common chorditis, are not associated with pulmonary symptoms, and show no bacilli in the sputum. Microscopical examination of small pieces of tissues shows the tubercular nature of the case. The author emphasized the possibility of a primary tuberculosis of the larynx, and the necessity of making not only a bacteriological, but also a microscopical examination, together with inoculation into animals of the removed tissues, if necessary.

The absence of bacilli in an early period, the only stage really amenable to local treatment, does not affirm the non-tubercular nature of the disease, no more than does the presence of bacilli not form a positive argument in favor of tuberculosis.

In regard to the treatment, the author expressed the opinion that we cannot foresee the favorable conditions which are apt to lead to recovery,—at least, in the clinical sense of the word,—but we cannot deny that there are cured cases. He has thus modified his first opinion as to the curability of laryngeal phthisis after consideration of the results obtained by Schmidt, Krause, and Heryng, who, at the last meeting of the British Laryngological Society, gave the indications for real treatment.

Massei related 9 cases, 3 treated with tracheotomy, 3 with the curettement, and 3 others with phenol sulphoricinate, as recommended by Ruault.

A Case of Severe Diphtheria.—In a clinical lecture MASSEI describes the results from antitoxic treatment in a severe case of diphtheria (sixth day): severe tumefaction; great quantity of putrid membranes in the throat and nose; purpura on the legs; glomerulo-nephritis; pulse weak, frequent; coma. The girl, 9 years old, was at the point of death, and antidiphtheritic serum was injected only from humane motives. Complete recovery followed. The author is of the opinion that it may not be necessary to use large doses of the antitoxic serum as a general rule, but that in severe cases, when the treatment is begun late and severe symptoms persist, it is necessary to repeat the injection. He is a partisan of the chemical theory, and thinks that a proportion between toxins and antitoxins is, in some cases, enough to insure recovery.

Sweden.

DR. F. EKLUND,
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SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM
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Stockholm.

Primary Septicæmia and So-called Cellular Pneumonitis.—N. KUTNEFF describes the case of a man, 48 years of age, who lived under bad hygienic conditions. In June, 1894, dyspepsia with constipation appeared, due to gastric and intestinal atony, and was followed by membranous enteritis and symptoms of acute muscular and articular rheumatism. A typhoid condition supervened; acute pneumonia developed, which became chronic, and exudative pleurisy on the right side, with thrombi of the lower extremities. The skin was dry, desquamating, muddy-gray in color, with pustular efflorescences in places. Improvement took place in the patient's condition for a time, but he suddenly grew worse after left crural thrombosis developed, together with increasing fever and strangury. Erysipelas of the right ear, the head, and neck also appeared. The patient vomited repeatedly. The urine contained only traces of albumin, but numerous lymphoid cells, mucus, streptococci and staphylococci, together with red corpuscles and large, flattened, epithelial cells. The sanguinolent expectoration also contained these microbes and cells. At the post-mortem examination the mesenteric glands were found to be somewhat swollen, firm, and partially sclerosed; the lungs emphysematous, œdematous, and atelectasic in places; the liver adiposed, and the kidneys intumescent. Kutneff states that during the epicrisis the temperature seldom, if ever, fell to normal during a period of seven months, that it fell rapidly several times during the two days preceding death, as much as 2.3° to 3.5° C. (4.1° to 6.3° F.) at a time, and that immediately before death it rose to 40° C. (104° F.)

A similar case seen by the author was that of a married woman, aged 45 years, who showed a typhoid condition during some time. There was dryness of the tongue and skin, the latter being of a muddy-gray color, slight bronchitis, anorexia, and constipation, and the expectoration showed lymphoid cells, red corpuscles, streptococci and staphylococci in abundance. Repeated thrombosis occurred in the left leg. The temperature, as a rule, was 37.5° C. (99.5° F.) in the mornings and 38.5° C. (101.3° F.) in the evenings, but went up suddenly several times to 39.5° or 40° C. (103.1° or 104° F.). After a continuous fever for more than two months the patient gradually recovered.

A third case described by the author was that of a land-steward, 22 years of age, who contracted a cold, felt much prostrated, and suffered from stitches in the side. He became weak, rapidly emaciated, dyspnœa set in, and right exudative pleurisy was followed by acute pneumonia. Examination of the sputum gave the same results as in the other cases. The author, therefore, believes that primary septicæmia is a general infection caused by pyrexogenous bacteria without any previous inflammatory focus as an agent. The gravity of the affection may vary greatly, depending, as in all infectious diseases, on the virulence of the germs and the resisting power of the individual. The symptoms—at least, in severer cases—very much resemble those of secondary septicæmia. After vague signs for several days, fever, tenderness, and pain appear, so severe as to closely resemble rheumatic fever. The typhoid state then develops, so marked that a case of primary septicæmia occurring during an epidemic of ileo-typhus might easily be mistaken for enteric fever. Generally inflammatory foci form during the course of the disease, due to localization of the germs, giving rise to thrombi, pneumonia, etc. The fever curve is characteristic, especially if the streptococcus is among the infecting agents.—*Hygiea*, lviii, 3, p. 278, 1896.

Diagnosis and Significance of Insertion of the Placenta.—A purely mechanical theory is advanced by G. LINDSTRÖM to explain the point of insertion of the placenta. Owing to distension or increase of the portion of the uterine surface supporting the placenta the points of insertion of the Fallopian tubes and round ligaments are displaced in such a way as to be opposite to the placenta. The form of the uterus itself assumes a different appearance, becoming rounder or broader at the top in cases in which the placenta is inserted upward toward the fundus, and more oblong in cases in which the placenta becomes attached farther down. Another type of configuration, more marked and more easily recognized, is that caused by the so-called tubal insertion. The author examined 100 women with a view of determining not only whether the anterior or posterior wall was the site of the insertion, but also the height of the insertion. In 45 cases the insertion was on the posterior wall, in 25 upward or in the middle of the wall, and in 15 cases lower down. In 33 cases the anterior wall was the point of insertion, 26 times in the upper or middle part, and 11 times lower down near the internal orifice of the wound. In 10 cases the insertion was in the fundus, and in 12 at the tubal orifices. In 8 cases an erroneous diagnosis was made. The control examination was made on the sixth to the eighth day of the puerperium.

The author points to the value of ascertaining the spot of insertion of of the placenta in cases of Cæsarian section, as being of material aid in the operation. In 26 cases in which the point of insertion was low, secondary hæmorrhage occurred not less than 13 times. The duration of labor was comparatively long in cases in which the site of insertion was at the tubal orifice, being on an average forty-one hours in primiparæ and thirty-three hours in multiparæ.—*Hygiea*, lviii, 2, p. 162, 1896.

Movable Kidney.—G. NAUMANN relates the case of a married woman, aged 32 years, who for three weeks suffered from pain in the renal region, more acute on motion. Bandaging gave no relief. The author diagnosed movable kidney and made an incision after Braun's method, applying four silk sutures through the latissimus dorsi, the sacrolum balis, and the quadratus lumborum muscles, and deeply into the parenchyma of the kidney on its convex side. Recovery followed and was permanent.—*Hygiea*, lviii, 2, p. 153, 1896.

Treatment of Gonorrhœa.—From the treatment of 100 cases of gonorrhœal urethritis treated by Janet's method, MAGNUS MÖLLER concludes that this treatment is superior to all others, insuring positive recovery if instituted within two to four days after the onset of the disease. When begun later, like all other local methods, it has but little effect. In subacute and chronic stages it is, as a rule, rapid and efficacious in its results, though overdoses may prove not to be harmless.

Gangrene of the Penis and Scrotum.—F. KAYSER describes a case of this kind from the Helsinborg Hospital. After the sting of a tick on the prepuce, paraphimosis developed; this was reduced within twenty-four hours, but the prepuce had already become livid and a small ulceration had developed at its inferior border. Violent pain was felt, and there was great tumefaction of the entire penis and scrotum. Gangrene set in at the spot of ulceration and rapidly spread, necessitating a radical operation for the removal of the affected portion. To this end Kayser made an incision through the skin eight centimetres above the root of the penis, eight centimetres in length, and vertically to the median line, and sutured the skin so as to fix it more firmly to the penis. He then lengthened the incision three centimetres on each side, and made another incision at each end of the first parallel with the penis, stitching up the lateral borders of the flap over the dorsum of the penis and of its upper border with the glans. Most of the sutures cut through, owing to erection, but a perfect recovery took place. *Hygiea*, lviii, 2, p. 151, 1896.

Clinical Notes and Lectures.

Pancreatic Diabetes.—DR. TALBOT JONES, of St. Paul, Minn., in an article on this subject in the *Medical Record* of May 23, endeavors to show the following points: 1. That a causal relationship is proven to exist, in a large proportion of cases, between "lean" or true diabetes mellitus and degenerative or destructive lesions of the pancreas. 2. That sugar is destroyed in the blood of diabetic animals (*a*) by the subcutaneous injections of a pancreatic extract and (*b*) by grafting the pancreas into the skeletal muscles and into the abdominal cavity. 3. That there are striking pathological analogies between true diabetes and myxœdema, and that in the latter disease success has also attended both injections and thyroid grafting, —a success achieved not only in animals, but also in man. 4. That the treatment of diabetes by means of a glycolytic ferment made from malt (Professor Lépine's method), while it decreases the quantity of glucose in the blood, does not wholly destroy it, and, *pro tanto*, is less successful than the treatment with extracts made from the pancreas. 5. That in the treatment of true diabetes with pancreatic emulsions a prerequisite to success is its introduction into the circulation so as to avoid the stomach chemistry on the one hand and the portal circulation on the other.

After due consideration of the foregoing propositions, three possibly successful methods of treatment appear available to the author: (*a*) By rectal injection of a properly-prepared pancreatic extract. According to most authorities the rectum is not a digesting but merely an absorbing organ. Thus introduced, the extract would escape digestion, and, being taken up by the lymphatics, would likewise escape the portal circulation. (*b*) By the subcutaneous injection of a sterilized pancreatic extract of the requisite strength, using the same antiseptic precautions as are now observed in injecting the diphtheria antitoxin and Koch's tuberculin. (*c*) By pancreatic grafting, which, in the lower animals at least, has been brilliantly successful. As the physiologists have now pointed out the way, it is to be hoped that practical results will follow close on the heels of their experimental investigations. Dr. Jones adds that when we remember that true pancreatic diabetes is as fatal to-day as it was in 1674, when Willis demonstrated the presence of sugar in the urine, any new and rational treatment holding out the slightest promise of success deserves and should receive a careful, thorough, and painstaking clinical trial in our hospitals. Physicians who are constantly using subcutaneously the diphtheria antitoxin, tuberculin, and thyroid extract, should not hesitate to employ in the same way a pancreatic extract; and surgeons who are daily doing the most formidable operations and invading successfully almost every cavity in the body should not shrink from grafting the third of a pancreas into the sheath of the pectoral muscle or into the abdominal cavity.

A Laryngeal Diaphragm.—Such a membranous formation was observed by P. BERGENGRUN in the larynx of a woman, 41 years of age, who for fifteen years had had some difficulty in respiration, without any disturbance of speech. The dyspnœa, at first slight, had increased gradually, until it became so intense as to cause the woman to seek medical assistance. The functional symptoms were as follow: Inspiratory depression of the subclavicular fossæ and the intercostal spaces; noisy, strident inspiration and expiration; feeble, but not hoarse voice. A rapid and slightly irregular pulse was noted; the general condition was not very good, but not bad; the heart, lungs, nose, and pharynx were normal. The larynx was small, the form, color, and movements of its different parts being normal. A little below the glottic space was a yellowish-gray membrane, shining like a tendon, and completely obstructing the trachea. In the neighborhood of the left arytenoid a small opening as large as the head of a pin was seen. It was the only orifice by which the air could pass. The membrane was incised as far as the posterior commissure on one side and almost as far as the anterior commissure on the other. There was but an insignificant hæmorrhage, and respiration immediately became noiseless. Four days later the introduction of Schrötter's ebonite tubes was begun, and on the tenth day No. 7 of the series could be passed and the voice and respiration had become entirely normal. The patient then left the clinic, and when seen, two months later, there remained of the diaphragm only two small subglottic projections at the anterior commissure.

The author regards it as remarkable, from a physiological stand-point, that no disturbance of the voice should have accompanied the almost complete cutting off of the air. Contrary to theoretical ideas, it would appear from this case that a very small quantity of air suffices for the production of normal sounds. It is probable that a greater force of the expiratory air-current made up for the small quantity; the larynx and the supra-laryngeal portions of the respiratory passages were acted upon with more force, and the value of the pharynx, nose, and sinuses as resonance cavities thus increased.—*Arch. f. Laryng. u. Rhinol.*, B. iv, H. 1, 1896.

Formation and Structure of the Optic Nerve.—In an article in the April number of the *Journal of Anatomy and Physiology*, Dr. Arthur Robinson, of Owens College, gives an interesting account of the formation and structure of the optic nerve derived from his researches on the embryos of man, the rat, cat, ferret, sheep, and rabbit. He accepts the view that the fibres of the optic nerve do not, as some have thought, arise from the epithelial cells which constitute the primary outgrowth from the brain, but holds that they spring chiefly from the cells of the retina which shoot up toward the brain, but in part from the brain growing down to the retina. The optic stalk itself is composed essentially of protoplasmic substance which develops into retiform sustentacular tissue and becomes converted into the optic nerve by the passage of nerve-fibres through its walls, the fibres being protected and supported by the external limiting membrane of the stalk. The specimens examined by Dr. Robinson showed that at their first appearance the nerve-fibres are found in the stalk only in its retinal portion, and even in the later stages they are most abundant near the retina. When the invasion of the stalk by the nerve-fibres first occurs they are limited to the ventral wall, and it is only when the canal of the stalk undergoes obliteration that the fibres are found in the dorsal wall of this process. He draws the conclusion from his researches that the retina is a portion of the brain-wall specially situated and modified to the proper performance of its function; and inasmuch as it is an outgrowth of the ventral part of the lateral wall of the thalamencephalon the retina may be looked upon as a modified basal ganglion and the optic nerves are association bundles bringing it into relationship with other parts of the brain.—*Lancet*, May 30, 1896.

Action of Tropical Climates and High Altitudes on the Blood.—Numerous writers have shown that high altitudes cause an increase in the number of hæmatins, and also in the proportion of hæmoglobin. Almost all admit that this is due to diminished atmospheric pressure, and that it is a phenomenon of adaptation, and that through this increase of red cells the organism becomes more rapidly accustomed to higher altitudes. The observations of Dr. H. F. Kohlbrugge, made at the sanitary station of Tosari, in the Island of Java, 1777 metres high, are not in accord with this view. In healthy persons (European and Javanese) spending one month at Tosari, as well as in healthy persons arriving from lower altitudes, the composition of the blood was the same as that of normal individuals inhabiting Europe or the lower regions of Java. At Tosari, therefore, the number of hæmatins did not increase with the surprising rapidity observed in temperate climates, particularly in Switzerland. In persons who had become anæmic through malaria—the principal cause of true tropical anæmia—the author observed a marked increase of red corpuscles; this, however, only took place gradually, as the general condition of the patients improved.

From these observations it would appear that the diminution of barometric pressure is not the real or, at least, not the only factor in the blood-making action of mountain-air. As regards the so-called tropical anæmia of healthy, acclimated Europeans, Dr. Kohlbrügge's researches confirm those of Eijkmann and Van der Scheer, showing that it is not a true anæmia, but simply a pallor due to the influence of the heat on the nerves of the cutaneous vessels of the skin. — *Genees. Tijd. v. Nederlandsch-Indïe*, xxxv, 5, 6.

Pharyngotherapy.—Some time ago, Heller, of Nuremberg, and Ziem, of Dantzig, described under this name a general method of treatment for infectious diseases, based on the theory that the majority, if not all, of such diseases have their point of departure in the nose and naso-pharynx, where are deposited the infectious germs floating in the air. The treatment consists in systematic lavage of the nose and naso-pharynx, thus destroying the germs on the surface and preventing or aborting the disease. According to R. KAYSER, however, such a method is of no practical value. A large number of infectious diseases, such as typhoid fever, tuberculosis, cholera, dysentery, etc., do not begin by the upper air-passages, and a large number, such as pneumonia, influenza, and usually tuberculosis, begin in the lower air-passages. In other words, the nose and naso-pharynx do not arrest all the germs which penetrate with the air, and from this fact alone pharyngotherapy cannot be considered as a general method of treatment, even prophylactic, of infections.

A second objection made by Kayser is that the asepsis obtained by lavage of the nose and naso-pharynx is purely imaginary. When it is remembered that such lavage is powerless to procure asepsis in cavities like the external auditory canal and the vagina, it will readily be understood what results it will give in such irregular and anfractuous cavities as those of the upper air-passages. Even admitting the possibility of procuring asepsis, half an hour later infection would again have taken place. The only value such lavage can have in infectious diseases is when there are morbid localizations in the mucous membranes of the nose and naso-pharynx.— *Therapeutische Monatshefte*, No. 5, 1896.

Clinical Forms and Treatment of Syphilitic Myelitis.—In a lecture on this subject DR. GILLES DE LA TOURETTE asserts that treatment would be more efficacious in these cases if instituted from the first appearance of spinal symptoms. The premonitory period of common syphilitic paraplegia is almost always insidious, and negligent patients only consult a physician when some disquieting symptom, such as nocturnal incontinence of urine, appears and naturally frightens them. As locomotion is at first but slightly interfered with, it is only when they feel a heaviness and almost uselessness of the lower limbs that they think of seeking medical help. By this time, however, spinal trepidation is already present, and secondary degeneration has had time to make some progress. Sometimes such patients do consult a physician, but the latter, not familiar with the manifestations of spinal syphilis, does not pay much attention to the heaviness and numbness complained of by the patients, who experience a certain amount of difficulty in walking, but the muscular strength of whose lower limbs seems to render their allegations at least problematical.

When syphilitic patients consult a medical man from time to time to ask whether it would not be well to resume antisyphilitic treatment, it is advisable for him not to limit himself to an inspection of the throat or the skin, but to examine the knee-reflexes, which he will often find exaggerated; he should then ascertain if there is not an abnormal sensation of lassitude after standing a short time, if walking is not difficult, and if micturition is not attended with some effort. If any of these symptoms can be discovered, active treatment, at once instituted, will often cut short an incipient myelitis.—*Bull. Méd.*, June 17, 1896.

Recent Suggestions in Therapeutics.

Airol in Blennorrhagia.—Wash out the anterior urethra with *boric-acid solution* and inject 10 cubic centimetres (2½ fluidrachms) of the following solution: *Glycerin*, 15 grammes (½ ounce); *water*, 5 grammes (1¼ drachms); *airol*, 2 grammes (31 grains). Repeat for four or five days. Four cases of complete cure after three to five injections. (LEGUEU, LÉVY, *Revue de Thér.*, May 15, 1896.)

Calcined Magnesia in Burns.—DR. VERGELY, of Bordeaux, in a case of phosphorous burn, conceived the idea of covering the burned skin, well soaked in water, with *calcined magnesia*, in order to cause the formation of a soluble and non-caustic *phosphate of magnesia.* The good results obtained in the parts not directly affected by the fragments of the burning phosphorus led him to try a combination of *boiled water* and *calcined magnesia* in all cases of burns without an eschar or with a superficial one. The effects have always been rapid and satisfactory. (*Jour. de Méd. de Bordeaux*, No. 6, 1896.)

Cascarine.—This is the active principle of the bark of the *Rhamnus purshiana*, and analogous to, if not identical with, the franguline contained in the bark of *frangula.* SCHOENLAUB recommends it as a substitute for *cascara sagrada*, in habitual constipation, in pills of 0.1 gramme (1½ grains), 1 to 4 being taken in the evening. The advantage of *cascarine* is that it acts with more certainty and without causing colic. (*Schweiz. Woch. f. Chem. u. Pharm.*, No. 12, 1896.)

Erodium as an Hæmostatic.—L. V. KOMOROWITCH calls attention to the powerful hæmostatic effects of the *Erodium cicutarium* (fam. Geraniaceæ) in cases of metrorrhagia and menorrhagia. He tried this Russian popular remedy in 23 cases, in 20 of which floodings were caused by metritis, in 1 by myoma, in 1 by cervical polypus, and in 1 by abortion. The remedy was always given internally in the form of a decoction, ½ ounce (16 grammes) of the herb to 6 ounces (185 cubic centimetres) of water, a tablespoonful every two hours. In all the patients the symptom quickly subsided, even in those who had been previously treated by *ergot* and *hydrastis Canadensis* without success. No accessory phenomena were ever observed, although in some cases the administration continued for several weeks. The *erodium* seems to exercise a direct tonic influence on the uterine muscular tissue, the organ growing distinctly firmer during the administration. In the case of cervical polypus the latter was found lying free in the vagina after two days' use of the decoction. (*British Medical Journal*, June 20, 1896.)

Eucaine, a Local Anæsthetic.—Chemically, *eucaine* is described as "methyl ether of a benzoylated oxypiperidinecarbonic acid." It is almost insoluble in water, but forms an easily-soluble hydrochlorate, which will be the salt most generally used, unlike cocaine hydrochlorate, does not decompose when boiled with water, and that its solution remains perfectly clear, and does not become flocculent, but requires neither carbolic nor salicylic acid as a preservative. *Eucaine hydrochlorate* has been used by Dr. C. L. Schleich and others with splendid results, it is reported. It was applied as a paint (on mucous membranes), or by injecting into the vicinity to be operated on in 1 to 6½ aqueous solution. The area of anæsthesia is said to be more extensive and to last longer than when cocaine is used. (*Am. Medico-Surg. Bulletin*, June 6, 1896.)

Gonorrhœa in Women.—De Smet washes the vulva in a 1 to 1000 aqueous solution of *formic aldehyde* and pours a 2 to 5 per 1000 solution into the vagina, washing carefully the cervix, fornices, and folds. If the cervical canal and uterine cavity are involved, he injects a 2 per 1000 solution, and if there is cervical laceration he leaves a tampon soaked in 1 to 1000 solution for two to three hours in the vagina. The treatment is applied daily, or every two days. (*Semaine Méd.*, June 3, 1896.)

Gymnastic Exercises in Muscular Atrophy.—Wiener reports a case of progressive muscular atrophy in which treatment by a course of gymnastic exercises was adopted. The patient was a man, aged 20, who had been affected with the disease for one year. The affection was of the facio-scapulo-humeral type. There was difficulty in raising the arms and in walking, and lordosis was marked. The usual electrical treatment was tried without improvement. Then a course of carefully-planned gymnastic exercises was commenced. After two months the patient could raise his arm, the gait improved, the lordosis was less, and later almost any ordinary movement could be accomplished; only some slight difficulty in going upstairs remained. The condition of the muscles visibly improved, and the muscles which were not specially exercised—for example, those of the face and tongue—remained wasted as before. The writer considers that the methodical use of muscular movements, such as the Swedish exercises, is likely to be followed by great improvement in such cases; but that such good results can hardly be expected where the disease has begun in early childhood, as in these cases there is probably some inherent defect in the muscles themselves. (*British Medical Journal*, June 13, 1896.)

Hæmoptysis.—Dr. Desplats, of Lille, advises, when the hæmorrhage continues in spite of the first measures employed, and when a preparation of *ipecac* is not at hand or it is not desirable to use it, to take half a glass of water, quickly dissolve in it a tablespoonful of ordinary salt, and give it as a single drink. The effect is sometimes instantaneous. If this does not succeed, ligature of the four members should be the last resort, the ligatures being loosened one by one, giving time for a clot to form, and gradually so as not to increase the arterial tension too rapidly. (*Jour. de Méd. et de Chir. Prat.*, June 10, 1896.)

Heat in Soft Chancre.—Dr. Audry, of Toulouse, has devised a modification of the heat treatment of soft chancre introduced three years ago by Dr. Welander, of Stockholm. Dr. Audry employs radiant heat supplied by the thermo-cautery, the button of which is held for a few seconds at a distance of three or four millimetres from the sore previously washed and dried. Should the point of the thermo-cautery be fine it must be brought to a white heat; if larger, to a dull-red heat. Exposure to this radiated heat for the period indicated has the effect of thoroughly drying the ulcer, on the edges of which there now appear sanguinolent striæ. Too long exposure determines a raising of the surrounding epidermis and a reddening of the skin. A single *séance* is stated to be usually sufficient to transform the chancre into a simple ulcer, which soon cicatrizes under the influence of any antiseptic powder. The rapidity of the healing is due to the absence of the scab that always follows the direct application of actual or chemical heat. The pain is said to be quite endurable, being less than when the actual cautery is employed. (*Lancet*, June 6, 1896.)

Xeroform.—This is a *tribromphenol bismuth*, intended to replace iodoform, and having the same indications and the same method of administration as this drug. Heuss finds that it is not toxic, not irritating to the skin or mucous membranes, and is without taste or odor. It possesses the combined properties of *phenol* and *bismuth;* being bactericidal, antiputrid, and a moderator of the secretions, it is valuable not only as an intestinal antiseptic, but as a topical application for wounds, the cicatrization of which it favors.—*Therap. Monatshefte*, April, 1896.

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(End of Editorial Department of Journal for August, 1896.)

MUSCULAR RHEUMATISM.

The pathology of this disease is still obscure. It occurs chiefly in those predisposed to gout or rheumatism. The exciting cause being chiefly wet, or cold, or exposure to draughts while perspiring. Stimulating and anodyne embrocations, heat, and electricity are recommended. In those predisposed to gout or rheumatism an antirheumatic analgesic is indicated. Salophen, combining both of these properties, appears to be the indicated remedy. It is prompt in relieving pain, agreeable to take, and leaves no deleterious after-effects. There is no more effective way of relieving lumbago, pleurodynia, and other forms of muscular rheumatism than by the administration of salophen. Its use, kept up for a few days after symptoms have disappeared, prevents a recurrence.

THE ABSORPTION OF PREPARATIONS OF IRON.

In blood therapeutics it is an accepted fact that inorganic iron preparations are practically worthless, from the fact that they are not absorbed to the extent necessary to produce the effect desired,—the increase of hæmoglobin and blood-corpuscles.

It would seem that the natural form of iron, as found in the tissues and particularly the liver, is Ferratin, as proven by the studies of Schmiedeburg, Marfori, and Filippi, and confirmed by Professor Chittenden, of Yale, and other high authorities.

Ferratin is absorbed from animal and vegetable food, and is stored principally in the liver, "to feed the blood."

Schmiedeburg and Marfori succeeded, by a complicated process, in combining the tartrate of iron with albumin, yielding an iron albuminic acid, or Ferratin. It is chemically and physiologically identical with the natural Ferratin, as it can be precipitated from pig's liver. Further tests have proved that Ferratin is quickly absorbed and assimilated, supplying the blood with the requisite amount of iron, increasing the appetite and stimulating the vital power, and markedly increasing body-weight.

Sajous's ANNUAL for 1895 gives indorsements of Ferratin from such authorities as Germain Sée, Jaquet, Banholzer, John Harold, and Hugo Wiener,—the foremost therapeutists of Germany, Italy, France, and Austria. In America, by Einhorn, of New York; Fackler, of Cincinnati; Chittenden, of New Haven; Perekhan, of Chicago; Spencer, of Cleveland, and others.

FERRATIN—THE FERRUGINOUS ELEMENT OF FOOD.

With the above title a valuable monograph lies on our table. We have carefully read the various chapters on the value of Ferratin in anæmia and kindred complaints, and, while wishing we had space to reprint the monograph entire, we must content ourselves with publishing a few leading facts. Schmiedeberg, in his article on the "Dietetic and Therapeutic Uses of Ferratin," covers the ground completely and gives a history of the preparation of Ferratin and much information valuable to the physician. Drs. Jaquet and Kündig, of the Medical Clinic at Basel, in their article "Ferratin in the Treatment of Anæmia," go very exhaustively into the subject, with a tabulated list of patients upon whom the new iron albuminoid was tried, with results, and in summing up state "One is surely justified in attributing to Ferratin a decided importance as a dietetic and therapeutic remedy." Dr. Fackler, of Cincinnati, is decided in his opinion of the value of Ferratin; as also John Harold, of London, Eng. Dr. Samuel Wolfe, of Philadelphia, is decided as to the value of Ferratin as a reconstructive. In fact, it seems that this new iron preparation continues to gain increasing attention.

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Selections from Society Proceedings.

FRANCE.

Congrès français de Médecine.

Albuminuria.—The prognosis of albuminuria was discussed by Dr. Arnozan, of Bordeaux, who stated that the present knowledge of chemistry was not sufficient to enable the albuminoid bodies to be distinctly differentiated, especially in the urine, where serin, globulin, and nucleo-albumin are to be found, besides peptones and propeptones. It is not yet certain whether there are not other varieties corresponding to special pathological processes. Albumin is not a part of normal urine; though it may be found in the urine of many apparently healthy individuals, the ultimate prognosis in these cases, as regards disease or mortality, cannot be definitely made. It is to be noted that the factors pointed out as giving rise to this physiological albuminuria are the same as those which increase a pathological albuminuria. Albumin may appear in the urine as a result of slackened circulation of blood in the kidneys, as a result of changes in the blood, or of lesions of the filtering membrane. Blood changes evidently precede the albuminuria in most cases, but it cannot be concluded from this that normal albumin passes directly into the urine; it is very possible that the kidney supplied with vitiated blood presents alterations that give rise to ordinary albuminuria. The elimination of abnormal albumin by the kidney is a truly depurative function which has been fully demonstrated.

As regards epithelial renal lesions, these are varied, and when they approach what is called inflammation it is to be presumed that the albumin is derived from the inflammatory exudate of the filtering membrane, as it is to be found in the exudate of all inflamed membranes.

Considered from a semeiological stand-point, albuminuria is an unreliable symptom, giving little idea of the extent and importance of the lesions present; its abundance or variations are of but slight assistance in making a prognosis. The study of the figured elements of the urine and of its chemical composition is of far greater importance. The state of the renal function, and not the amount of albumin, forms the basis of prognosis. However, the presence of albumin is not a symptom of no value, as has been claimed, for, no matter what may be its characteristics, it indicates a vascular or nutritive disturbance of the kidney, and consequently gives unerring testimony of disease of an organ the integrity of which is essential to health and to life.

Albuminuria is present in a number of conditions. When accompanied by œdema, cardiac disturbance, and the toxic troubles of uræmia, it constitutes Bright's disease,—an affection which is, without exception, fatal; at least, in its chronic form. All albuminurias, however, do not thus terminate. Albuminuria accompanies most severe fevers in the acute period (infectious and toxic nephritis). It usually passes off with the disease which provokes it; but, even apart from cases in which the infection is complicated by a generalized subacute nephritis (renal form of pyrexia), the presence of albumin aggravates the prognosis of infectious diseases. The mortality is greater in cases accompanied by nephritis. If albuminuria come on during convalescence, and especially if it persist after the pathogenic germs of the disease have disappeared from the urine, it tends to become chronic, and the patient is on the road to Bright's disease, which may supervene sometimes after a long period, but not in a fatal form.

Albuminuria complicates most cases of poisoning, and even the prolonged use of many remedies; so that the physician is called upon to exercise the greatest discretion in his therapeutic efforts. The ulterior prognosis of these toxic albuminurias has not been well established. Albuminuria frequently affects an intermittent or cyclical form, appearing in the urine passed during the day and disappearing from that passed at night. The oscillations are parallel to those of the urinary toxicity, the albumin appearing when the greatest quantity of noxious principles is eliminated by the kidney. The same variations are observed in chronic, permanent albuminuria, and probably under the same influences. An interesting syndroma, cyclical albuminuria does not merit the name of a morbid entity. Albuminuria minima represents an alteration of the same kind,—the remains of an infectious nephritis, latent *début* of Bright's disease, or often, also, the manifestation of a mild auto-intoxication. The latter, indeed, plays an important rôle in the pathogeny of albuminurias, and consequently in their prognosis; it explains the presence of this symptom in dilatation of the stomach, enteritis, diseases of the liver, overexertion, perhaps even in nephritis due to cold, and in burns. While an acute auto-intoxication may lead to an acute nephritis, which afterward follows an independent course, chronic and mild auto-intoxications maintain their influence over albuminuria induced by them, and this may be cured when the pathogenic cause has been removed. The causes which render such albuminurias permanent are numerous, but among them the first rank should be given to bad diet, bad hygienic conditions, and especially to heredity. In fact, one may inherit from one's ancestors defective kidneys ready to succumb at the first attack. Albuminuria may be transmitted from the mother to the newborn infant; and the child born of a woman with albuminuria, and particularly with eclampsia, is more than any other individual predisposed to succumb to the immediate or remote results of an infectious nephritis.

Albuminuria frequently complicates diabetes, which it does not ameliorate, as has been thought, but which it may replace, a true nephritis being established. The amount of albumin in these cases is of importance, for, the larger the quantity of albumin, the smaller the quantity of sugar becomes, and the prognosis is graver on account of this progression. In tuberculosis albuminuria may assume various forms: infectious nephritis of slow, but certain, progress, as in renal tuberculosis; the albuminuria of auto-intoxication with great variations, as in tuberculous patients with fever, dilatation of stomach, and hypertrophy of liver; nephritis due to intoxication by tuberculin in cases of attenuated tuberculosis, and perhaps in pretuberculous albuminuria.

To sum up, albuminuria is due to two series of causes: infections and intoxications. If these are intense from the outset, disorganization of the kidney, uræmia, and death may rapidly supervene; if moderate, albuminuria may exist without inducing important disturbances, and in such cases, once the cause is removed, it will disappear in its turn, unless bad hygienic conditions, too long duration, or heredity do not render the kidney less resistant and thus permit the setting up of a chronic nephritis the evolution of which will be independent of the original pathogenic cause.

GREAT BRITAIN.

British Medical Association, Carlisle.

Relative Advantages of Forceps and Version in Cases of Moderate Pelvic Contraction.—Dr. Milne Murray, of Edinburgh, opened the discussion on this subject. He said that by the use of forceps intra-uterine manipulation is avoided and also the dangers of compression of the cord and traction on the neck to which the child is exposed after the performance of podalic version. In cases of flat pelvis the ordinary long forceps are not very satisfactory, and it was thought that this was due to the compression of the child's head by the blades in the transverse diameter of the pelvis and the consequent bulging of the head in the conjugate diameter. This, however, is not the true explanation, as with the head lying transversely at the brim he has found it possible to compress it with the forceps to the extent of one and a half inches without giving rise to any bulging in the opposite diameter. Under such circumstances the head swells vertically by a kind of telescopic action. The real difficulty of delivering the head through a flattened brim by means of long forceps was that they did not enable traction to be made in the axis of the inlet, and the amount of force wanted is greater when the pelvis is flat than when it is normal. By the axis-traction principle this difficulty is entirely overcome, as by means of axis-traction rods the line of traction can be made to coincide with the axis of the inlet and the angle of error is thus abolished; even in cases where the head has not yet entered the brim and no lateral tilting has occurred it is possible to deliver with axis-traction forceps, and with such an instrument he has delivered on several occasions living children through a conjugate of three and a quarter inches. A pair of forceps made to coincide with the curve of the normal pelvis is not quite suited for cases where the pelvis is flat. To overcome this difficulty Dr. Murray has invented an instrument called the adjustable axis-traction forceps. The traction rods are carried down for some distance, and then pass backward at right angles, giving an horizontal limb. The handle is slipped on to the horizontal limb and can be adjusted at any point according to circumstances. To throw the angle of traction farther back, as is desirable in cases where the pelvis is flat, the traction handle is slipped along the bars to a greater distance from the handles than usual. Dr. Murray affirmed his belief that any case in which turning is indicated can be more safely dealt with by means of axis-traction forceps.

Dr. Purslow, of Birmingham, did not entirely condemn version, and the common objection that if perforation is necessary it is more difficult to perform it when the head comes last is not, in his opinion, true.

Dr. Fothergill said that, in his opinion, there was nothing to be claimed in favor of version except its antiquity. He did not believe in the advantage of the wedge which was supposed to be obtained when the base of the skull came first, because the pressure from above, which was almost always made during the extraction of the head, counteracted this advantage by flattening the head down. He referred to six cases of flattened pelvis in which he had delivered living children by means of Milne Murray's axis-traction forceps.

Dr. Munro Kerr, of Glasgow, questioned whether in a flat pelvis the blades of the forceps were ever applied over the forehead and occiput, but thought that one usually lay to one side of the occiput and the other to one side of the forehead. If the head were grasped thus obliquely it would bulge in the conjugate diameter of the brim. It was not uncommon to find the pelvis had more room on one side than the other, and the ease or difficulty in delivery depended on whether the occiput was directed to the roomy or small side of the pelvis. He thought that in such cases if the occiput were directed to the small side it was best to do version, whereas if it were directed to the roomy side forceps were the proper treatment.

Dr. Murdoch Cameron, of Glasgow, also referred to pelves where there was more room on one side than the other, and pointed out how a woman might have a still-born baby if the occiput were directed to the narrow side and might be delivered spontaneously if the occiput were directed to the opposite side. He showed and described a form of forceps by means of which the head can be grasped in the biparietal diameter while it is lying transversely at the brim. The instrument is easily applied and admits of traction being made in the axis of the brim. He pointed out that one of the commonest causes of the forceps slipping off when traction was made was that the occiput was directed backward. Under such circumstances the occiput should be rotated forward by the hand and the forceps then re-applied.

The Relations of the Morbid Conditions Dependent on or Associated with the Presence of Streptococci.—The discussion on this subject was introduced with a paper by Dr. G. Sims Woodhead, of London, who drew attention to the fact that there was a great deal of doubt as to the part the streptococcus pyogenes usually played as an etiological factor. For the most part, he considered the streptococcus to take a secondary, or adjuvant, action to that of other pathogenic organisms which might be regarded as easily taking the primary or preliminary rôle, thus, as it were, paving or preparing the way for the subsequent action of the streptococcus. An interesting fact was that the streptococcus occurred along with other pyogenic organisms in the buccal cavity, the pharynx, and œsophagus; on the surface of the skin; in the glands of the skin; in the clothing; in dust, and in every possible position to which animal secretions could gain access. It was for these reasons that the streptococcus came to be present in many diseases, chiefly as a secondary agent in all probability. He pointed out the fact of its frequent occurrence in the exudations of diphtheria in company with organisms associated with the names of Löffler, Klein, and Klebs. He drew a comparison between the different false membranes in which are found the true diphtheria bacillus, the streptococcus anginus, or a mixture of both the aforesaid organisms. He also noted the probability of the bacillus coli communis being one of the primary organisms to the action of the streptococcus. There was a tendency to speak of or to describe morphological differences between groups of organisms with common functions and which give rise to similar products; and also, on the other hand, to ascribe different functional activities to organisms identically the same. There were six different individual pyogenic streptococci, which were divided into three groups, each with a separate name, though all were the same morphologically and as regards their mode of growth when under cultivation. In Group 1 were the streptococcus pyogenes œdematus (Flügge) and the streptococcus septicus, both of which presented common morphological characters, and both proved fatal to mice and rabbits when injected into the veins, and in most cases when injected subcutaneously. Group 2 comprised the streptococcus erysipelatosus and streptococcus septopyæmicus, which were also identical in morphological characters and growth; they developed less readily in the tissues of the human body and were not so fatal to mice and rabbits. In Group 3 the streptococcus articulorum, when injected into the veins of rabbits, attacked the joints, setting up inflammation and producing usually a fatal result. To this group also probably belonged the streptococcus anginus. These last were found in the exudations and secretions of measles and scarlet fever, in rheumatism, in false membranes, and in association with other organisms such as the diphtheritic bacillus and the staphylococcus albus, aureus, or cyaneus; in abscess in the skin, furuncles, and elsewhere; in inflammatory processes in mouth and fauces; in otitis, enteritis, and peritonitis along with bacillus coli communis, and in all superficial skin affections, especially in weakly patients. They all, no doubt, possessed a wide distribution and occurred in many diseases. The following points as to mode of action and life-history were worthy of note: Firstly, it must undergo great modification as regards the part it played in the production of its particular products; secondly, it was found so often along with other organisms that its so-called products might perhaps be due to its symbiotic existence; and, thirdly, the state of the tissues on which it acts must play a very strong part in the nature of the reactions of its products, life-history, and functional activity. It was generally known that outside the body the streptococcus might lose its virulence, and that it was only by growth in serum-bouillon, and by passing the organism through a series of rabbits from time to time, that its full powers could be maintained. It was only by using the methods of Marmorek that the discrepancies of the earlier observers as regards its virulence and propagatory power could become at once explicable. That the streptococcus lived, as it were, two separate existences, the one saprophytic, or "vegetative," in nature, where, owing to the fact that the agencies inimical in character to its growth being few and of different kind, it became diverted along lines favorable to its existence. It here led, therefore, a strictly vegetative life, devoting its energies to reproduction and to resisting the action of light and similar destructive agents. On the other hand, during its parasitic life it waged a warfare for its very existence, and as a result of this struggle produced substances paralyzing to living tissue. It now lived at a higher level, so to speak, and formed products which in its vegetative life it did not produce, because its existence was comparatively easy and its energies were chiefly expended on reproducing itself. After living its parasitic life the streptococcus did not grow so easily outside the body, and, besides, it was only after its toxin-producing powers were lowered that it could reproduce itself at the rate it did while living its purely vegetative life, and *vice versâ.* The resemblance of the secondary action of the streptococcus to that of the primary action of other organisms—such as bacillus diphtheriticus, bacillus coli communis, bacillus prodigiosus, and bacillus typhosus—must be taken into due consideration.

Dr. Robert Muir, of Edinburgh, said that there were differences of opinion as to the many kinds or species of streptococci which at one time or another prevailed in different diseases or in various modifications of the same disease. He was of the opinion that the work of Marmorek would tend to show that this was not the case. Also, that in the same disease at one time there was a stationary local process and at others a spreading one, as in the cases of erysipelas and pneumonia, where the disease at first flourishes and then dies down. There was a great analogy and many points of resemblance between these two diseases, and the analogy was capable of being pushed very far. There seemed in many cases to be a production of immunity with rapid recovery; in others this was not the case, the disease leading to suppuration. The streptococcus might be placed half-way between the staphylococcus and the pneumococcus. He did not think much of the theory that the virulence depended on the site at which it found entrance into the body.

Dr. Forbes-Ross, of London, thought the theosophy of the dual existence of the streptococcus, if absolutely true, was highly interesting and instructive, and should tend to explain and clear up many differences and clinical divergences of the same diseases in different individuals and in other diseases where the streptococcus was known to exist; of course, taking into consideration personal peculiarities and resistance. The theory of the secondary action of streptococcus was very seductive and enticing, as it tended to clear up satisfactorily the continued presence of streptococci in various parts of the alimentary canal during health without ill effects to the individual; and whether the bacillus coli communis was a generic name comprising many and various organisms, or was individually descriptive of modifications of the same identical organism, the "secondary," or "adjuvant," theory seemed to throw light on those cases where streptococcus was found taking an active rôle, perhaps as the result of previous irritation or devitalization by the action of other organisms in the alimentary canal, especially in children. He believed that children needed to acquire a certain amount of immunity to even the commonly regarded innocuous organisms found in the alimentary canal of adults and existent there with no ill effects. He did not, for a moment, doubt but that previous wounding, bruising, or injury might be considered "primary" to the "secondary" action of streptococci and other pus-producing organisms,—*e.g.*, abscess of the lung after pneumonia, pelvic cellulitis, etc.—*Lancet*, August 15, 1896.

Third International Congress of Dermatology, London.

Connection of Tuberculosis with Diseases of the Skin other than Lupus Vulgaris.—Dr. Nevins Hyde, of Chicago, in a paper based upon arguments and facts, stated that it may now be accepted that primary and secondary infection of the skin with tubercle bacilli may take place, and that auto-infection of the skin may also occur. The diversity between the several clinical forms of cutaneous tuberculosis may be explained by the quantity of micro-organisms present in any given case, by differences in the tissues on which the germs are implanted, and by accidents of exposure of the infected region. The various skin lesions (other than lupus vulgaris) due to tuberculosis may be classified as follows: Those in which the bacillus tuberculosis has been demonstrated,—(1) verruca necrogenica, (2) tuberculosis verrucosa cutis (Riehl and Paltauf), (3) tuberculosis papillomatosa cutis (Morrow's type), (4) fibromatosis tuberculosa cutis (Riehl), (5) elephantiasis tuberculosa cutis, (6) tuberculosis cutis ulcerativa, (7) tuberculosis gummatosa ulcerativa (cutaneous scrofuloderm), (8) lymphangitis tuberculosa cutanea (Besnier), (9) tuberculosis cutis serpiginosa ulcerativa, (10) tuberculosis cutis fungosa, and (11) tuberculosis nodosa atrophica (lupoid form). Skin lesions in which the bacillus tuberculosis has not always been demonstrated, but in which there is every reason to believe that it will be in the future,—(1) lupus erythematosus, concerning which Dr. Hyde had come to the conclusions (*a*) that it does not originate from nor is it the source of tuberculous infection, (*b*) it occurs in non-tuberculous subjects as a result of causes as yet undetermined, and (*c*) it also occurs in tuberculous subjects and then there exists a relation between the two; (2) erythema induratum scrofulosorum (Bazin's disease); (3) lichen scrofulosorum; (4) tuberculosis suppurativa et bullosa acuta (Hallopeau); (5) a group of acneiform, sycosiform, and follicular disorders in which it is possible that tuberculosis may be responsible for some of the results; (6) keloid, and (7) ulcus molle complicated with tuberculosis. In the last group the author named (1) a few eczematoid disorders (neurodermatites), (2) erythema pernio, (3) exceptional forms of erythema multiforme, (4) some of the melanodermata, (5) purpura of the cachectic, and (6) a few of the drug dermatoses.

DR. HALLOPEAU, of Paris, insisted on the necessity of early recognition of tuberculous lesions of the skin. This diagnosis could be effected by (1) the possibility of transmitting tuberculosis from such lesions by a series of inoculations of the morbid matter; (2) the presence of the bacillus tuberculosis in the tissues of the lesions; (3) the production of similar eruptions, such as lichen scrofulosorum, under the influence of tuberculin, and (4) the production of the symptoms of a reaction and visible changes in the skin by the hypodermatic injection of tuberculin. But none of these conditions can be regarded as a *sine quâ non*. The types of elementary skin lesions which have up to the present been connected with tuberculosis are: (1) sclerotic and warty tuberculosis, where the process involves the papillary body; (2) the anatomical tubercle; (3) tuberculous gummata; (4) tuberculous tumors resembling mycosis fungoides; (5) tuperculous ulcerations; (6) erythema (lupus erythematosus), and (7) other superficial forms of tuberculosis of the skin, such as lichen scrofulosorum, suppurative folliculitis, and the like. The multiplicity of these various manifestations is explained by the different liability of the various constituent elements of the skin, the state of the health, and the age of the patients attacked.

DR. RADCLIFFE CROCKER, of London, laid stress on the fact that, while there are a certain number of diseases of the skin directly due to the presence of the bacillus tuberculosis, there are many other skin diseases which, though they are not due to this organism, find a favorable soil in those persons who seem to be predisposed to invasion by the bacillus. Examples of such a condition are to be found in persons who present the phenomena of easily-excited bone disease, glandular enlargement, etc.,—clinical conditions which come under the head of the "scrofulous diathesis." Cases were narrated and drawings shown in illustration of this. It was advisable to retain the word "scrofuloderma" for application to some conditions of the skin which were attended by involvement of the glands, extensive suppuration, and ulceration of the skin.

The Duration of the Period of the Contagion of Syphilis.—MR. JONATHAN HUTCHINSON, of London, opened a discussion on the above subject.

He said it was universally admitted that primary and secondary manifestations of syphilis were contagious. No doubt, cases are met with where contagion has occurred very long after the primary sore, but these are exceptions, and Mr. Hutchinson considered that contagiousness had generally ceased by the end of the first year, and that it was very exceptional indeed for it to continue more than two years. He had always allowed patients to marry after two years, and he could only remember two cases where the children of such marriages had shown any signs of syphilis. He had seen cases where the power of transmitting syphilis had lasted longer. In one case a man who had never had syphilis had brought three of his children in succession to Mr. Hutchinson, and they were all suffering from congenital syphilis derived from his wife; later the husband contracted syphilis from kissing his own child. In a large majority of the cases it is only the eldest child who suffers, but occasionally more. In all the cases of vaccino-syphilis which have been recorded the vaccine has been taken from children under 8 months, never from children over a year old. This fact seems to prove that a case of hereditary syphilis ceases to be infective by the end of the first year.

Professor Campana, of Rome, did not think that it was possible to fix with certainty the limit of the duration of the contagiousness of syphilis. Undoubtedly some manifestations of syphilis were not infective, such as the gumma, and they might say that those lesions which tended to undergo caseation were not capable of transmitting the disease; but should such a tertiary manifestation occur before the secondary stage has come to an end, even a gumma may prove infective. Probably during the whole of the time that the disease is hereditarily transmissible the disease is contagious. If antisyphilitic treatment has been properly carried out, the disease and its results have probably disappeared by the end of the third year.

Professor Lassar, of Berlin, said that general statements with regard to syphilis have often very little meaning. The contagiousness of syphilis persists as long as any syphilitic signs appear, but the intensity of the contagiousness diminishes as time goes on. The localization of the tertiary manifestations is probably a great element in preventing infection from them, and that they are incapable of communicating the disease has by no means been proved.

Dr. H. Feulard, of Paris, considered it certain that in different persons the length of the contagiousness of syphilis varied greatly. For three or four years from the primary infection syphilitic manifestations appear and recur from time to time; during the whole of this period there was risk of contagion, and therefore during this time patients should not be allowed to marry. Contagiousness in rare cases may persist still longer,—for five, ten, or fifteen years,—and in one case even twenty years after the primary infection a case had transmitted the disease. Local irritation seemed to be a cause of eruption, leading to late transmissions. Thus, the use of tobacco and in children dentition have been met with as exciting causes of these late eruptions. Treatment seems to have little influence on the duration of contagiousness of syphilis.

Dr. Tarnovsky, of St. Petersburg, said he had seen many cases in which contagiousness had lasted seven or eight years and one case had led to infection after fifteen years.

Dr. Blaschko, of Berlin, said the question had its theoretical and practical side. Theoretically a case of syphilis was infectious as long as the bacillus of syphilis was present; practically infection rarely occurred after three or four years, though in one case he had seen it after twelve years.

Malignant Syphilis.—A discussion on this subject was opened by Professor Haslund, of Copenhagen, who began by saying that the term "malignant syphilis" had been somewhat loosely used, but that he would apply it to those cases in which extensive ulceration appeared not long after infection. The name should never be applied to cases in which there was wide-spread tertiary ulceration; severe symptoms might be present in these cases, but they were not cases of malignant syphilis. So far as the primary sore is concerned, there is very little to note, and certainly extra-genital sores are not specially prone to be followed by it. Professor Haslund has never seen it occur later than the first year after infection. The prognosis is comparatively favorable, and the disease, even without treatment, tends to a spontaneous cure. Of the cases under his care occurring in males more than two-thirds lasted less than two months. As to the frequency of malignant syphilis, among 8691 cases of syphilis treated in the Copenhagen Municipal Hospital during fourteen years malignant syphilis has been observed 39 times, and with equal frequency in men and women. It is difficult to ascribe it to any particular cause. It is certainly not in the virus, as cases of malignant syphilis do not give rise to malignant syphilis. It has been attributed to a general weakness on the part of the patients, but it has been observed in those who are otherwise strong. Professor Haslund is inclined to think that it is liable to occur in families where the ancestors have been but little affected with syphilis, so that there is little power of resistance against the disease. As to treatment, mercury should not be given until the temperature is normal, and the patient should have tonics and general hygienic treatment.

Professor Neisser, of Breslau, said that the characteristics of malignant syphilis were the severity of the general symptoms and the great tendency to the formation of large pustules and extensive ulcers; these appear early. The ulcers cannot be gummatous in origin, for the ulceration is not at all serpiginous in form, and treatment with iodides has but little influence on the course of the disease. The cause is, in all probability, a special predisposition to the disease on the part of the patient, and it is not due to the excessive administration of mercury. Though cocci of various forms, especially staphylococci, are to be found in the ulcers, yet they are to be looked upon as the result of a secondary infection. Malignant syphilis may appear both in the acquired and inherited forms. The prognosis is good, but ordinary antisyphilitic treatment is of very little value. General tonic treatment is that which is followed by the best results.

Professor Benjamin Tarnovsky, of St. Petersburg, said that an attack of syphilis was liable to become exceedingly severe if, at the same time that the body became infected by the syphilitic virus, it were also infected by pyogenic organisms; thus, when staphylococcus pyogenes aureus and albus (accompanied sometimes by a special form of bacillus) find in certain organisms a suitable soil, they tend to render the primary sore phagedænic and to set up suppuration in the lymphatic glands, and to cause pyosyphilitic lesions on the surface of the body. Pyogenic organisms may infect a patient suffering from syphilis during any portion of the secondary stage, but only rarely during the tertiary period. Appropriate treatment can cause the re-absorption of the pyosyphilitic eruption. Anything depressing the general health tends to assist the infection of pyogenic organisms, such as alcoholism, diabetes, acute fevers, etc. Mercurial treatment commenced at an early stage of the disease and systematically carried on for two to three years is of great value in dealing with severe forms of syphilis. In the centre and north of Russia the intra-muscular injection of preparations of mercury seems to have the most rapid effect, and in this way may be used calomel, perchloride of mercury, the yellow oxide, and also the salicylate of mercury. Of all these the last is the least painful and therefore the most useful.

Professor Schwimmer, of Budapest, thought that malignant syphilis might develop in either the secondary or tertiary stage. The prognosis was not particularly good. Mercury and potassium iodide are of little value. Tonics were of the greatest value. In one case he had tried, merely as an experiment, spermin; after the fifth injection the ulcers had improved, and after the twentieth injection cicatrization began.—*Lancet*, August 15, 1896.

UNITED STATES.

New York Surgical Society.

Erysipelas Toxins.—A committee,—consisting of Drs. L. A. Stimson, A. G. Gerster, and B. F. Curtis,—appointed by the society to investigate the use of erysipelas toxins in cases of malignant disease, have made the following report upon the treatment:—

"Both before and since our appointment as a committee we have been able to observe, individually and together, a considerable number of cases treated by this means, and in no case have we found any amelioration which held out a prospect of ultimate cure. We have, on the contrary, observed in some cases that the rate of growth of the disease was much more rapid during the treatment. The treatment also imposes a severe tax upon the strength of the patient, and apparently hastens the cachexia in most cases.

"We believe that in the instances of apparent cure or marked improvement the correctness of the diagnosis is open to doubt.

"We therefore submit:

"1. That the danger to the patient from this treatment is great.

"2. Moreover, that the alleged successes are so few and doubtful in character that the most that can be fairly alleged for the treatment by toxins is that it may offer a very slight chance of amelioration.

"3. That valuable time has often been lost in operable cases by postponing operation for the sake of giving the method of treatment a trial.

"4. Finally, and most important, that, if the method is to be resorted to at all, it should be confined to the absolutely inoperable cases."—*Annals of Surgery*, July, 1896.

New York County Medical Association.

Pilocarpine in the Uræmia of Bright's Disease.—Dr. Charles J. Proben gave the details of three cases in which the use of pilocarpine was followed by a rapidly uniform and fatal action. He was led by this experience to protest against the use of this drug in the treatment of uræmia, for it has proved itself, not alone in his hands, but in those of others, an untrustworthy and dangerous drug. He does not doubt that similar experiences could be recorded by others were it not for the reluctance of offering failures for just criticism. The loose statement of text-books, that this remedy may be employed with safety, impress the reader that the drug may be resorted to with impunity. In Bright's disease, especially that form in which the circulatory appendages are involved, occurring generally in the senile state, cardiac degeneration incapable of detection takes place, and if, for any reason, the use of pilocarpine may seem indicated, the drug should certainly be proscribed. When he was interne at Charity Hospital, the general routine treatment for uræmia was hot-air baths and pilocarpine injections, and he recollects that cardiac failure and pulmonary œdema were frequent causes of death, coming on shortly after its administration. Why it is that pilocarpine can be given with impunity in some diseases and should prove so dangerous in others, as in nephritis, he is not prepared to say, save that the general invasion of the vascular system by pathological processes produces cardiac changes which impair its energy, making it unable to cope with the depressing effects of the poison given. It has been established, and cannot be controverted, that pilocarpine is a marked cardiac depressant and a dangerous remedy to administer in uræmia, that its sphere of usefulness is but a limited one, and that it should be banished from the therapeusis of Bright's disease.—*New York Medical Journal*, July 18, 1896.

Kentucky State Medical Society.

Eye Diseases and Blindness in the Colored Race.—A paper on this subject was presented by J. Morrison Ray, of Louisville, who has made a comparative study of the eye diseases peculiar to the negroes of his locality, most of whom show a trace of Caucasian blood, thus differing from the negroes found in the cotton-fields and sugar-plantations of the extreme South. At his request, Dr. Crittenden Joyes carefully tabulated, from the records at the University at Louisville, 1000 consecutive cases of eye disease, exclusive of defects in refraction, as they presented themselves for treatment previous to May 1, 1896. This included both the white and colored cases, the proportion being 579 whites to 421 colored.

COMPARATIVE TABLE OF 1000 CASES OF EYE DISEASE (CONDENSED).

	Whites.	Negroes.
Diseases of the lids,	90	50
" " cornea,	80	107
" " conjunctiva,	276	149
" " iris, ciliary body, and choroid,	35	70
" " lens,	31	22
" " muscles,	34	6
" " optic nerve and retina,	14	6
" " eyeball and orbit,	7	4
" unclassified,	12	7
Total,	579	421

As seen by the table, the negro race is remarkably prone to certain forms of eye inflammation, and, on the other hand, presents an apparently complete immunity from certain others. Of the 1000 cases tabulated, 140 were cases of lid troubles. There was not a single case of trichiasis or entropion in the negro, and of 7 cases of epithelioma all were in whites. On the other hand, hordeola, chalazia, and eczema were noted as 50 per cent. more common in the negro.

Affections of the conjunctiva furnished 425 cases,—276 white, 149 colored. In a study of these a most notable feature is the much larger percentage of the phlyctenular variety of conjunctivitis in the negro, and the practically complete immunity of the black to trachoma, only 2 cases being recorded to 63 in the white.

In the study of corneal diseases, as presented in the table under consideration, there were found 187 cases,—80 white, 107 blacks. Corneal inflammation more often than any other form of eye disease is apt to be the result of some vicious constitutional diathesis. Therefore, we should expect a large preponderance of these diseases among the colored. The statistics show that they are 40 per cent. more common in the negro.

The variety of corneal disease most rife is that form of relapsing destructive ulceration characterized as phlyctenular or strumous. Unlike what is true of the whites, this ulceration is as often found in the adult as in the child. That portion of the eye commonly known as the uveal tract, iris, ciliary body, and choroid, furnished us in our study 105 cases,—35 whites, 70 negroes. Out of 58 cases of acute iritis, 43 were in blacks. Of these 43, 33 were shown to be syphilitic. The iris and ciliary body are the parts of the eye first showing the ravages of syphilis, and the negro seems to be many times more prone to this complication. Sassure asserts that 70 per cent. of the negro population of the South either inherits or acquires syphilis.

In the study of iris diseases in the negro, the statistics prove a point for a long time noted and emphasized by the author,—namely, the peculiar proneness for gummatous infiltration to accompany the inflammation. Of 6 cases of gumma of the iris found, all were in negroes. Not only is the iris frequently the seat of such formation, but the only cases of gumma of the ciliary body that have come under his personal care have been in this race. It has been stated that syphilis in the negro does not present itself in the malignant form often seen in the whites, and that it responds more quickly to proper treatment. With this observation the teachings of the statistics presented do not agree. The forms of syphilitic iritis and cyclitis, with extensive condylomatous developments quickly ruining the eye, are found most often in this race, and, while they respond promptly to proper treatment, the inflammation has usually been of such a violent nature as to destroy the usefulness of the organ before the constitutional effect of the remedial agent has been obtained.

Diseases of the crystalline lens offer 53 cases for study,—31 whites, 22 negroes,—showing no great difference in the tendency to cataract development in the two races. The optic nerve and retina furnish 20 cases for consideration,—14 whites, 6 blacks. Of these 6, 5 were cases of primary atrophy of the optic nerve. The frequency with which non-inflammatory optic atrophy is found in the negro is familiar to all, many of them being cases in which it is impossible after thorough examination to find the cause for its development.—*New York Medical Journal*, July 18, 1896.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

Dr. F. Levison,
Referent for den Dansk Litteratur vedrörende: Almindelig Medicinsk Pathologi og Therapi, deri indbefattet, Nerve- og Sindssygdomme, Pädiatrik, Obstetrik, Gynäkologi, Hygieine, Demographi, Retsmedicin, Pathologisk, Anatomi, Bakteriologi.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

Dr. Levison,
Norrevoldgade, 13,
Köbenhavn.

Labor after Symphysiotomy.—Th. B. Hansen (*Hospitals-Tidende*, p. 597, 1896) observed the case of a woman who, three years previously, had been delivered by symphysiotomy, and who, without difficulty, gave birth to a well-developed child weighing 3250 grammes ($6\frac{1}{2}$ pounds), which, however, died in parturition. On account of a prolapse of the cord immediately after the delivery of the child the two branches of the symphysis separated about four centimetres; a strong bandage was applied to the pelvis and five weeks later the woman was able to walk a mile without difficulty and the distance between the two portions of the symphysis was only one centimetre.

Antidiphtheritic Serum.—Sörensen (*Hospitals-Tidende*, p. 521, 1896), physician to the hospital for epidemic diseases in Copenhagen, gives the results of his trials with antidiphtheritic serum of different kinds (German, French, and Danish). He had formerly reported that his experiments with German serum gave no proof that the course of diphtheria was sensibly changed by its use. He has since tried the effect of French and Danish serum in a large number of cases, and, in his opinion, the injections are not capable of altering the nature of diphtheria sufficiently to change it into a benign disease, the number of lethal cases being the same with or without the injections; nevertheless, in cases in which the injection has been made early in the disease the diphtheritic process seems to have some tendency to remain localized in the pharynx without affecting the air-passage below.

Mental Depression and Uric Acid.—LEVISON (*Hospitals-Tidende*, p. 353, 1896) treats of the relation of mental depression to uric acid and controverts the arguments of the Danish *savant*, Professor Lange, who for years has tried to establish the theory that the uric-acid diathesis (by which term is meant an hyperproduction of uric acid) may give rise to a special form of mental disease characterized by strong mental depression, unaccompanied by any hallucinations, and appearing in periods, with free intervals of varying duration. In the opinion of Lange, this disease is due to the toxic action of the uric acid on the central nervous organs. Levison claims that hyperproduction of uric acid in the body does not give rise to mental depression, as demonstrated by many experiences in pneumonia, leucocythæmia, and other diseases, and he shows that uric acid has no toxic action at all, Umber, Weintraud, Ebstein, and many other authors having proved that it may be formed in excess in the body and that it may be injected into the blood without causing symptoms of poisoning.

The real explanation of the fact that mental depression is seen in patients suffering from uric-acid gravel is that the irritation of the kidneys produced by the gravel gives rise to a multitude of nervous symptoms; it causes pain in the lumbar region, in the lower and sometimes in the upper extremities, and in the abdominal wall; it causes nausea and sometimes constipation and may occasionally, in nervous individuals, cause symptoms of mental depression by reflex action from the kidneys. That this is the case is made probable by the fact that the mental depression, as well as the neuralgia and pain in the lumbar region, is rapidly cured by the use of remedies or mineral waters which dissolve the uric-acid crystals and relieve the kidneys from these causes of irritation.

The author relates some typical cases observed by himself and others in nervous patients suffering from mental depression and uric-acid gravel, rapidly cured by the use of Fachingen water. In persons without taint of nervous affections there may be some mental suffering, but nothing approaching to a mental disease. In children the connection between uric-acid gravel and nervous symptoms is frequently noted. Levison has observed such cases in children 2½ years old and upward. In one of them the child was not only ill-tempered, morose, and disposed to outbursts of tears, but had regular attacks of night-terror. The urine contained numerous uric-acid crystals, some small, others combined in clusters and irregular in shape. Treatment by Carlsbad water was instituted, after which the night-terror only returned once and the child became cheerful. After some time the mother of the child neglected the treatment, and all the previous symptoms re-appeared, but were again rapidly checked by repetition of the treatment.

Percussion of the Heart.—Straudgaard (*Nordisk medicinsk Arkiv*, Nos. 2 and 8, 1896) has thoroughly tested the different methods of determining the limits of the heart by percussion in experiments made in 78 cadavers, the limits being marked by colored ink or by needles, and afterward compared with the result of the autopsy. In Straudgaard's opinion, the old, ordinary form of percussion still gives the best results, though in some cases it may be completed by percussing in the intercostal interstices alone. The method of Schott, consisting in percussion with one finger while a finger on both sides is pressed down to check the vibrations of the chest, is, in his opinion, almost valueless, as the results are less reliable than those of the old method.

Treatment of Constipation.—Halk (*Ugeskrift for Läger*, p. 601, 1896) treats obstinate constipation and intestinal diseases successfully by enemata of oil, after the method of Reiner. Olive-oil is the best, but, as it is rather costly, the author generally employs purified rape-seed oil. The injections are made slowly and carefully, and the patients are told to retain the oil as long as possible, sometimes for several hours. Every day an injection of 50 to 250 grammes (1½ to 8 fluidounces) of oil is made, with the result that defecation becomes easy, the flatulence diminishes, and in cases where the mucous membrane of the bowel is more seriously affected the ulcers and chronic catarrh improve.

Intestinal Calculus.—Kjar (*Hospitals-Tidende*, p. 445, 1896) relates a case of calculus in the intestines. Examination of the patient revealed an indolent, hard tumor, covered by natural skin, in the right crural region. The tumor could not be displaced. As the patient wished to be operated on, an incision was made, and it was found that the hernia contained the cæcum with its appendix, and that the hard body lay in the cæcum. By incision of the bowel a stone 9 grammes (2¼ drachms) in weight was evacuated; the patient recovered. By chemical analysis the calculus was found to consist mainly of bismuth and phosphoric acid, and it was proved that the patient had some time previously taken bismuth in large doses.

Clinical Notes and Lectures.

Toxicity of the Gastric Juice in Epilepsy.—Various writers have shown the important rôle played by auto-intoxication in epilepsy. The increased toxicity of the urine after the attack has been demonstrated by Demy and Chouppe, Féré, and others, while the toxic power of the blood-serum has been studied by d'Abundo, Guérin, and Pierret. Recently Agostini, of Perugia, has investigated the toxicity of the gastric juice, and finds that after the attack, when injected into guinea-pigs, it causes disturbances not produced by normal gastric juice. These disturbances consist of a marked fall of temperature, a psychical prostration, motor incapacity, slackened respiration, paralysis, and finally death in tonic and clonic spasms. This toxic power is slightly increased before the attack and immediately after, and varies according to the duration and intensity of the fit. Should the result of these observations be confirmed by further ones, it would have a certain bearing on the treatment, and to indicate that washing out of the stomach and the use of antiseptics would be of value. In the opinion of the author, bromide of potassium in these cases acts by lessening the toxicity of the gastric juice.—*Gaz. degli Osped.*, No. 38, 1896.

Difficulties Encountered in Reduction of Dislocation of the Hip.—By far the most noteworthy recent contribution to the important subject of hip-joint luxation is the Samuel D. Gross prize essay contributed by Dr. OSCAR H. ALLIS. The author maintains the following propositions: 1. The capsule is the most important agent against traumatic dislocations of the femur. 2. For the laceration of the capsule and dislodgment of the head of the femur, the femur is employed as a lever. 3. Every lever has a fulcrum; the fulcra required in dislocations of the femur are bony and ligamentous. 4. Dislocation by thrust, if possible, is infrequent. 5. Reduction by circumduction is the simplest, the most brilliant, and the most hazardous of all modes of replacement.

Allis summarizes the functions of the ligamentum teres as follows: 1. The teres does not prevent dislocation, since it is possible to tear it from the head without completely dislocating the head. 2. The ease with which the teres can be torn after division of the capsule is also proof that its function is not that of a ligament. 3. While it is true that the teres may be torn without a dislocation taking place, it is also true that without rupturing it a complete dislocation is possible. 4. If the teres escape rupture in the process of dislocation, it is highly probable that it will be ruptured during efforts at replacement, if circumduction be employed. 5. As there is no evidence that the teres contributes to the normal security of the joint, therefore insecurity or weakness of the articulation after the reduction of a dislocation cannot logically be attributed to its loss; nor can its absence be said to favor subsequent dislocations. 6. After reduction no unusual position of the limb or foot (such as flexion, inversion, or abnormal eversion) can justly be attributed to the lost function of the teres.

The functions of the capsule are: 1. To check the movements of the femur against a tendency to transcend the limits of safety. If one will dissect every structure from the joint but the capsule, he will be surprised at the resistance this single structure will offer to displacement. 2. To offer a large surface for the attachment of muscles that contribute toward the safety of the joint and preside over the movements of locomotion. 3. To furnish a large surface for the display of synovial membrane. 4. To form a shut sac for the retention and distribution of synovia.

The following *résumé* of the functions of the fascia lata is given: 1. It forms the sheath or envelope of the most important walking muscles of the thigh; during progression the tension of this fascia (through the gluteus maximus and tensor vaginæ femoris) is of the utmost advantage; through the same muscles it steadies the head of the femur in the socket. 2. It checks adduction of the extended thigh through the ilio-tibial band. 3 It checks outward rotation of the extended thigh. 4. It assists the hamstring muscles and the sciatic nerve in checking flexion of the extended limb. 5. It checks a tendency to hyperflexion of the thigh upon the abdomen. 6. It contributes largely to man's ability to stand at rest. 7. After reduction of a dislocation at the hip-joint the fascia lata and the untorn portion of the capsule are our main reliance in retaining the head of the femur in place. If the feet are tied together, the fascia, and nothing else, presses the head into the socket. 8. After fracture of the neck this ilio-tibial band is relaxed during adduction. 9. As adduction tightens the ilio-tibial band and abduction relaxes it, the latter position is voluntarily assumed in the early stage of hip disease. 10. As flexion of the extended limb tightens the fascia lata and drives the head into the socket, this manœuvre elicits pain in the early stage of hip disease.

In considering the sciatic nerve and hamstring muscles in relation to luxation, Allis shows that if the femur is abducted at right angles with the pelvis the leg must be flexed to relax the nerve and the hamstring muscles. If, however, the femur is carried still farther outward, the head may burst through the capsule and be dislodged inward. In this case the nerve, of course, escapes; but should the head be shifted from the position of thyroid luxation to that of dorsal luxation there is danger to the nerve, since there is but one possible path for a dislocation inward to take in order to become a dislocation outward, and that is between the hamstring tendon and the socket; and since the tendon of origin of these muscles is within half an inch of the socket, and the nerve is nearer, if anything, under no circumstances can the head be circumducted and carried outward without traumatism, more or less severe, to the nerve. If the sweep of the knee through which this may be effected be a large one, and especially if there be sufficient extension of the leg on the thigh to shorten and make tense the nerve, then there is great danger that the head will pass between the nerve and the tendon.

If such a condition be suspected, the fact may be ascertained by having an assistant push upward upon the knee in the direction of the long axis of the shaft of the femur, while the surgeon, by extending and flexing the leg, will find that the nerve may be alternately tense and relaxed in the popliteal space if it be over the neck, and the head out of the socket. In such a case the successful reduction of the head will release the nerve, but the traumatism may have been so severe that a prolonged neuritis or a partial or complete paralysis may result. If the head, in its transit from within outward, pass between the nerve and the socket, the former may be bruised a little, but not detached from the tendon, and will lie, after dislocation, between the head or neck and the tuberosity.

When dislocation of the neck occurs, the danger of hooking up the nerve through the efforts at reduction will be greatly increased if the head in passing outward catches up the nerve and tears it from its attachments.

This is no random statement. Bigelow, Morris, and Johnson have caught it up in experimental work, and Koons did it in actual practice.

If the nerve be hooked up during the reduction, the following conditions will be present: The nerve will cross the front of the neck and lie beneath the untorn parts of the capsule and the tendon of the psoas muscle; it then descends through the rent in the muscular partition to the adductor magnus, beneath which it descends to the popliteal space. At least three inches of the nerve are taken up in this detour, and hence the thigh must be flexed on the pelvis and the leg on the thigh, to accommodate them to the shortened nerve.

If the dislocation occur through flexion, adduction, and rotation inward, the capsule may yield and the head may escape outward and downward without touching the pelvis in the descent. In such cases Allis has seen the head fall directly upon the nerve, from which it can slip to either side.

In considering the mechanics of reduction, Allis describes an exceedingly ingenious and seemingly practical way of fixing the pelvis and apparently gaining full control over the femur. In describing the phenomena of dislocation, the author gives special directions for cleaning out the socket, having frequently observed in his work that so much detached muscular material has been carried into the socket during the course of reduction as to give the restored limb a constrained position. If any portion of the capsule is torn off, it must be the pelvic, and Allis holds that all foreign substances which enter the socket must enter its lowest segment. It is clear that the side of the head that drives the capsule before it into the socket cannot be made available to remove it; this must be done by the opposite side; hence, if the capsule has been pushed into the socket from the dorsal aspect, the first step is to flex and abduct, while if the entrance has been made from the thyroid aspect the femur must be flexed and adducted to accomplish the same end. After engaging the inverted capsule the femur should be rotated inward to tighten the Y-ligament and drive the head down into the socket, while at the same time the knee is raised and the foreign matter is removed from the socket. The success of the method will be apparent by the free and unembarrassed motion of the femur. From the experimental stand-point Allis would urge upon every one the importance of testing the degree of extension and adduction after every reduction.

Allis lays down as an axiom that every dislocation must be restored through the steps in the reverse order of the displacement. For the replacement of the head by direct steps in inward dislocation he offers the following directions: 1. Flex and abduct the femur. 2. Make traction outward. 3. Fix the head by digital pressure and adduct.

The medical profession has long practiced, with variable success, methods somewhat resembling that which has just been described. Authors recommend: 1. To flex and adduct the thigh. 2. To make perpendicular traction upon the knee, and follow traction by adduction. 3. To make traction with adduction, using the foot in the groin as a fulcrum. 4. To place the patient astride a bed-post, using it as a fulcrum while extension and adduction are made. 5. To make traction and adduction while an assistant with a fillet passed between the thighs makes traction upward and outward. All of these have been recommended, but success in their employment does not depend upon the scientific application of the principle. In all adduction is made a prominent feature; but adduction, if attempted too early, defeats its own end. He does not favor reduction by the indirect method,—*i.e.*, rotation. In considering the reduction of dislocation outward, Allis calls attention to the striking resemblance between two very diverse conditions,—viz., a dislocation primarily inward into the thyroid depression, but which has by secondary influence been rotated outward, so that the foot points outward and backward; and another, dislocated primarily outward, but which by reversed action also yields a foot turned outward or even slightly backward. As these two conditions are the result of forces directly opposed to each other, their reduction will evidently require equally diverse methods. In neither form of dislocation will there be evidence of decided fixation, nor will the limb refuse to lie parallel with its sound fellow. Extreme outward rotation in which the inside of the foot tends to look outward—the heel forward and inward—is hardly possible in any condition save that of a primary dislocation inward, with external rotation, the head being controlled by the **Y**-ligament, which is untorn. The outward rotation of everted dorsal is rarely beyond rectangular eversion. To determine whether the case in question be an everted dorsal, let the operator make a gentle attempt to rotate still farther outward. This will be checked because the **Y** ligament lies in front, and external rotation will make it tense. Not so with the "thyroid reversed"; in this case the **Y**-ligament lies behind, and rotation, after the foot looks backward, can still be increased. If the foot look backward or outward, find the head; to do this, locate the inner condyle,—it points in nearly the same direction as the neck. After this locate the great trochanter; it will lie internal to the dividing line between the two divisions of the bone, when the head has been dislocated primarily inward; but if the head be dislocated primarily outward, the trochanter major cannot lie internal to this line. Lastly, make direct pressure upon the head. If it be a reversed dorsal, the head will sink; if a shifted thyroid, the upper end of the femur will have a bony support; if it be a dorsal with eversion only, the head can be felt by direct pressure; if it be a shifted thyroid, the trochanter can be felt as well as the head. It must be evident, therefore, that retracing the last step of dislocation is not a simple or unimportant matter and that a confident rational procedure will only be based upon a knowledge of the path taken by the head. As we are now dealing with dislocations outward, the first thing to do with an everted dorsal is to convert it into an "inverted dorsal." To do this, flex (this will relax the **Y**-ligament), abduct, and rotate inward. The operator should observe carefully that the head follows the manipulation; if it does, he has retraced the last step of dislocation and is ready to undertake the second step. In the second stage of dislocation the head left the region of the socket and fell outward and downward until arrested by the yet untorn part of the capsule; hence, to retrace the second step, lift. To complete the second stage the head must be turned inward to the region of the socket, and it should be noted that the tendon of the hamstring muscle and its attendant, the great sacro-sciatic nerve, are directly in the way.

This is a most critical moment, for the head must be turned in to the region of the socket, and has no other path than between the tendon and the socket. To do this while the limb is lifted vertically with the leg flexed at right angles to the femur, which relaxes the tendon and nerve, turn the leg as a crank downward and inward until the heel looks footward. Do not use violence. If obstruction be experienced, it cannot at this stage lie in the capsule; it cannot lie in anything over which violence will prevail. It will lie in one of three things: either the head strikes bone, in which case it must be lifted higher; or it strikes the tendon, or the nerve. In case it strikes the tendon it can be readily shifted, and the escape of the tendon may be followed by a similar escape of the nerve. The author has frequently caught them in succession, and has so caught up the nerve as to flatten it over the head, and being spread out twice its original size it has barred his progress to the socket. Therefore, he urges caution at this stage, for if the nerve be caught and force applied it will effectually bar all entrance to the socket, slip off the head and escape, or slip off the head upon the neck of the femur, from which it can with difficulty be disengaged.

If the head has met with no obstacle in rotation, it is now ready for the last step. The head of the femur rests upon a ridge between the outer and inner planes. It has reached its present position by being lifted to a level with the socket and rotated obliquely beneath it. There are three courses open to it now: it can fall outward, pass inward into the thyroid depression, or ascend obliquely upward into the socket. There are two ways for accomplishing a happy replacement: The first is by traction. By this means the knee is lifted skyward, which relaxes the remnant of capsule while an assistant with his thumbs makes direct pressure upon the head in the direction of the socket. This may reduce it; if not, the operator may bring the knee down in extension, the assistant still keeping up the pressure upon the head. The manœuvre should not be attended with violence or dispatch. The surgeon, if he encounter resistance, should be warned by it, and retrace and modify his course. Usually the head will pass noiselessly into the socket. The second, or direct, method is to employ the Y-ligament of Bigelow as a fulcrum to drag the head into the socket. The reader will bear in mind the position of the head: it lies below the socket, and must be directed obliquely upward and outward. If now the knee, with the leg flexed, be carried directly downward in extension, the remnant of untorn capsule (Y-ligament) will be made tense and the head be lifted into the socket. Should the head slip outward upon the dorsal aspect, it must be replaced by lifting, and, instead of extending the knee directly downward, it should be a little abducted and then extended. If, on the contrary, the head slip inward into the thyroid depression, then the knee should be adducted and the Y-ligament tightened a little by inward rotation. If now extension be made, the head will be directed in the course of the socket.

Allis ascribes failure of reduction to lack of skill or facilities in the operator; obstacles that prevent the head from entering the socket; obstacles pushed into the socket by the head; the sciatic nerve hooked over the neck of the femur. If the nerve has been caught up, the immediate effect will be flexion of the thigh upon the pelvis, owing to the sudden shrinking of the nerve. There will be imparted to the limb a springing motion which it can get in no other way.

Diagnosis is founded upon a tense, cord-like nerve in the popliteal space. The operator has but one course to pursue, namely: 1. Redislocate the femur; patient supine. 2. Extend the thigh. 3. Flex the leg on the thigh to relax nerve. 4. Turn the ankle of the flexed nerve out until the leg is horizontal; the head will now look perpendicularly downward. 5. Shake, rock, jar, adduct, and abduct, with a view to disengage the nerve from the neck and make it drop down below the level of the head. 6. Rotate the head into the socket without making the nerve tense,—*i.e.*, by not flexing the femur.—*Therapeutic Gazette*, July 15, 1896.

Diffuse Papillomatous Degeneration of the Nasal Mucous Membrane.—DR. G. HUNTER MACKENZIE, of Edinburgh (*Lancet*, August 15, 1896), describes the case of a man, aged 30 years, who applied to him for treatment on April 2, 1896, complaining of partial nasal obstruction and stuffiness. In May, 1887, he appeared to have both nostrils electro-cauterized on account of thickening of the mucous membrane. There was no history of syphilis, but he was somewhat alcoholic. The mucous membrane in both nostrils was studded throughout by numerous sessile growths, varying in size from a pin's head to almost a grain of rice, the size of the great majority of them being about intermediate between these two extremes. They were most abundant on and about the upper regions (roof, outer wall, and septum), but many were located on and about the inferior areas of the nose. Both nostrils appeared to be equally affected. Several of the larger growths were removed with the cold snare, but the greater number could be detached only by means of the nasal curette. Four months afterward there was no recurrence. The growths were examined microscopically by Dr. R. F. C. Leith, who submitted the following report: "Microscopical examination shows the undoubted papillomatous character of the growths. The central core of fibrous tissue varies in thickness, but is mostly thin. It consists of young, vascular, fibrous tissue. The epithelial covering is of considerable thickness, and, while the lower cells are columnar and elongated, the rest are typical, flattened, and squamous, such as are present in an ordinary papilloma of the skin. Many of the cells show prickle processes. The outmost cells are somewhat flattened, but there is no cornification such as the stratum corneum of the skin presents. The conversion of the columnar, glandular, epithelial covering of the nasal mucous membrane into cells exactly similar to the Malpighian layer of ordinary stratified squamous epithelium is very interesting."

Nasal papillomata are of rare occurrence. The few cases hitherto recorded have generally been instances of single, less frequently of multiple, growths, and then histological characters have usually been rather of the fibrous than of the true papillomatous character. Hence the term "papillomatous fibroma" which it has been proposed to apply to them. In several instances they appear to have been simple hypertrophies of the nasal mucous membrane. Ordinary mucous polypi, it may be mentioned, occasionally develop papillomata on their surface, especially if they have been exposed to external irritation.

Aluminium Instruments.—As aluminium is now extensively used in the manufacture of various instruments, the following facts, noted by Dr. P. A. E. Richards, will prove of interest: He was using an aluminium spatula for transferring small portions of different powders to test-tubes, and, having wiped it clean, had laid it down. In a few minutes' time he noticed that it had become covered with what closely resembled a white growth, and although he removed this it formed once more. When carefully examined this white deposit was seen to consist of a brush-like mass of filaments radiating in all directions, not unlike hyphæ of a vegetable growth, standing erect on the flat surface of the blade. This continued to grow quite visibly, but at length overbalanced and crumbled to a bulky white powder, which qualitative analysis proved to consist of alumina. A few experiments soon indicated that mercuric iodide had been the initial cause of this, as the substance at once produced a similar result with another piece of aluminium. He next tried various salts of mercury, including the two chlorides, the nitrate, sulphate, and oxide, and found that they all had more or less the same effect. Indeed, a minute globule of the metal was sufficient to start the "growth." The reason of this curious action would seem to be that mercury is deposited in the metallic condition on the aluminium, forming an amalgam, which at once acts on the moisture present in the air or on the surface of the metal to form alumina and liberate hydrogen. The mercury being again set free by this reaction once more attacks the aluminium, thereby prolonging and increasing the action indefinitely. A small strip of this metal, weighing half a gramme, was left in contact with powdered mercuric chloride for about a couple of minutes, then well washed and dried with a cloth. Action at once proceeded, and after an hour the aluminium was again thoroughly washed, dried, and then weighed. The loss in this interval of time amounted to a little over 8 per cent. of the total weight; in fact, the strip had been perforated in several places. The action is so curious as to be well worth repeating by those interested.—*Lancet*, July 18, 1896.

Facial Paralysis in the Newborn after Spontaneous Labor.—Knapp reports the case of a woman who was delivered spontaneously of a child weighing 4000 grammes, labor lasting twenty-four hours and a half. The membranes ruptured at the beginning of labor. The woman, who was a III-para, had a moderately, but generally, contracted pelvis. As soon as it was born the child was seen to be suffering from left facial peripheral paralysis; a considerable depression in the frontal and parietal regions of the left side corresponded to the promontory, and it was surrounded by collateral œdema involving the temple and the mastoid and preauricular regions. The author attributed the paralysis not to the bony depression of the parietal compressing the motor centre of the facial, but to the subcutaneous collateral œdema compressing the branches of that nerve. Cases of this kind have rarely been recorded.

Diagnosis of Pleural Effusion.—Baccelli draws attention to a sign formulated by him as an aid to the differential diagnosis of fluids in the pleura. If the patient is made to utter the word "*trentatre*" (= Italian 33) in a whisper, every letter of the word will be heard in case the fluid is very thin, but in proportion as this becomes heterogenous, and especially if purulent, the letters are gradually lost up to final disappearance of all conduction. The first letter to go is *r*, then *t*, then *n*, and finally the vowel sounds. To hear this Baccelli phenomenon one should use direct auscultation in the antero-lateral and inferior regions of the thorax, and without any stethoscope. The author goes so far as to say that even if the whole symptomatology of the case indicate a purulent effusion, the presence of this transmission of the whispered voice would be sufficient to negative such a diagnosis. The theory that every pleurisy is tuberculous finds no favor in the author's eyes. In the treatment sodium salicylate is recommended in the early stages and digitalis purpurea, digitaline, and caffeine in the later stages, when the urine is rather scanty.—*British Medical Journal*, August 15, 1896.

Lactation and Atrophy of Uterus.—Dr. H. M. Vineberg, of New York, finds that a true process of atrophy goes on quite independently of even relative debility or anæmia. Indeed, in women who remain feeble after labor or become weak from any cause, external or internal, and in patients anæmic before pregnancy, the uterus tends to remain large. Subinvolution, in fact, is, as has long been recognized, a morbid condition; but Vineberg finds that when involution goes on to its full completion the uterus is reduced to a size smaller than that of the non-parous organ. The author's tables are valuable. This condition—post-puerperal superinvolution—is principally seen in nursing women, and from this circumstance has been termed "lactation atrophy." It is normal and desirable, and is temporary, becoming permanent under rare and unfavorable circumstances. When the lying-in woman cannot suckle, the medical attendant should try to bring about superinvolution. This course, Vineberg believes, will save her from the development of a host of maladies due to subinvolution.—*American Journal of Obstetrics*, July, 1896.

The Blood-corpuscles in Diphtheria.—This subject has been studied by J. S. Billings, Jr., of New York, with especial reference to the effect produced on the blood by the subcutaneous injection of diphtheria antitoxin and its accompanying horse-blood serum. The author gives (*Medical Record*, April 26, 1896) the following summary of his investigations:—

1. The red corpuscles of the blood in diphtheria undergo a diminution in number in cases of moderate severity and in severe cases. Regeneration is slow.

2. The leucocytes are increased in number in all but two classes of cases,—exceptionally mild cases and exceptionally severe ones. As a rule, the amount of leucocytosis is directly proportionate to the degree of

severity of the case. The leucocyte-curve shows no correspondence to the clinical course of the disease. The number of leucocytes often remains higher than normal for days after all inflammatory phenomena have disappeared. The leucocytosis is similar in character to that seen in pneumonia and scarlet fever, the increase being in the so-called polynuclear forms.

3. The percentage of hæmoglobin falls coincidently with the number of the red corpuscles and to the same relative degree. But the regeneration of the hæmoglobin takes place much more slowly than that of the red corpuscles.

4. In cases treated with antitoxin the diminution in number of the red corpuscles is much less marked than in those cases treated without it; in a majority of the cases no such diminution takes place. The leucocytes are apparently unaffected by the antitoxin. The hæmoglobin is also much less affected in the cases treated with antitoxin, thus confirming the statement as to the red corpuscles.

5. In healthy individuals injected with antitoxin the red corpuscles show a very moderate reduction in number in about one-half the cases. The hæmoglobin is correspondingly affected. The leucocytes are apparently unaffected by the injections.

6. No peculiar characteristic changes in the morphology of the corpuscles were to be made out.

7. It is improbable that any information of prognostic importance is to be gained by examination of the blood in diphtheria.

8. The antitoxin treatment of diphtheria has no deleterious effects upon the blood-corpuscles. On the contrary, it seems to prevent degenerative changes which would otherwise be brought about.

Recent Suggestions in Therapeutics.

A Modified Method of Administering Oxygen and Ether.—Dr. H. A. Hare, of Philadelphia, states that the clinical results which have so far been obtained from the administration of ether and chloroform vapor when combined with oxygen-gas seem to prove beyond all doubt that the oxygen decreases the danger of the anæsthetic, and to a large extent obviates the difficulties which surround the administration of these drugs, and most of the untoward effects consequent on their use. Thus, when oxygen is given with ether, vomiting is less frequently met with, excessive pallor is rarely seen, and post-operative depression seems to be largely avoided. As a general rule, however, it has been the custom of physicians and surgeons, who have employed oxygen-gas in combination with ether or chloroform, to place the anæsthetic in a wash-bottle and then allow the oxygen-gas to pass through it in such a way that the patient received in the inhaler a mixture of anæsthetic vapor and oxygen, the mixture being made by the passage of the oxygen-gas

A Modified Method of Administering Oxygen and Ether (*continued*).

through the liquid anæsthetic in the bottle. An evident disadvantage of this arrangement is that the quantity of anæsthetic which is volatilized can only be in direct proportion to the volume of oxygen-gas which is forced through the wash bottle, and therefore with every increase in the quantity of vapor which the patient receives he must also receive an increased quantity of oxygen. It has been claimed, too, by those who have employed the ether and oxygen combination most frequently, that in a large proportion of cases a greater length of time is required for anæsthetizing, and that in some cases it seems almost impossible to get the patient under the direct influence of the drug. Dr. Hare believes that this difficulty lies in the fact that, as soon as a large quantity of oxygen-gas is used to convey a large quantity of anæsthetic vapor to the lungs, the patient passes into a condition which is called by physiologists apnœa. The respiratory centre is no longer irritated by the normal proportions of carbonic acid in the blood, and therefore sends out feeble respiratory impulses; and, as the patient does not breathe as rapidly or as deeply as before, the result is that very small quantities of the anæsthetic are taken into the body. Dr. Hare has employed an apparatus which he suggests as a substitute for the one heretofore used. It consists of a funnel-shaped piece of leather having a greater diameter in one direction than in another, into which is fitted a piece of soft felt or spongio-piline almost a quarter of an inch thick. In the under surface of the leather cone is inserted a small metal tube, and at the opening of this tube a small hole is cut in the spongio-piline. The ether is then poured upon the spongio-piline in the cone, in the apex of which is placed some absorbent cotton. The oxygen enters the cone by means of a rubber tube attached to the metal entrance mentioned. By this arrangement several objects are accomplished: 1. The supply of oxygen can be delivered to the patient in varying quantities without altering the amount of the anæsthetic given. 2. Any quantity of anæsthetic can be employed without necessarily increasing the oxygen. 3. The leather cone prevents the rapid evaporation of ether from the outer side of the spongio-piline. 4. The spongio-piline, being much more porous than an ordinary towel, will retain a large quantity of ether in liquid form when this drug is poured upon it. 5. If desired, the same apparatus can be used for the administration of chloroform by removing the metal cap on the smaller end of the cone, as in this way the patient will receive not only the anæsthetic vapor and the oxygen, but also fresh air, through the end of the cone in such quantities as the physician deems wise. In these cases it is best to use the attachment known as the Krohne and Senseman "respiration indicator," a small feather on a pivot which moves to and fro with the motions of respiration, thereby providing the physician with a gauge as to the rapidity and force of the respiratory movements. The soft felt is very cheap, and a fresh piece can be used for each patient. (*Therapeutic Gazette*, July 15, 1896.)

Antidiphtheria Serum by the Mouth.—De Minicis (*Gaz. degli Osped.*, July 19, 1896), finding his hypodermatic syringe out of order on his arrival in a case of diphtheria, determined to try the effect of antidiphtheria serum by the mouth. The result was eminently satisfactory. Since that time the author has had an opportunity of treating four other cases in a similar manner. In each case the effect was quite as good as if the serum had been given hypodermatically, and no evil results followed,—no gastric disturbance, no skin eruption, and no joint or renal affection. Before deciding as to the dose required the author thinks further experience desirable. In the five cases the dose given was the same as would have been given hypodermatically. The serum was administered in iced milk or pure.

Dysentery.—In an epidemic at Grenoble Dr. Testevin obtained good results from the use of hot injections of *beech creasote* to influence the local lesion. The formula is as follows: *Beech creasote*, 1 gramme (15½ grains); *tincture of opium*, 10 drops; *boiled milk*, 20 grammes (5 fluidracms); *boiled water*, 200 grammes (6½ fluidounces). For one injection. This treatment appeared to be antiseptic, slightly hæmostatic, and calmative. The rectum was first washed out with a 1-gramme (15½ grains) solution of *boric acid* and *salicylic acid* and the patient then given the *creasote* injection, being recommended to retain it as long as possible. In some instances it was retained over night, and recovery was then rapid. Occasionally it was necessary to place a small suppository of *cocaine* and *belladonna* in the rectum in order to insure toleration of the injection. Three such injections in twenty-four hours usually sufficed to bring about recovery. *Calomel* and *salol* were also given internally. (*Jour. de Méd. et de Chir. Prat.*, June 10, 1896.)

Erysipelas.—Koester has, within three years past, treated one hundred and thirty cases of erysipelas by means of local applications of *vaselin* combined with measures intended to combat the symptoms of individual cases. His results have been most satisfactory, and from a comparison of the method with others, such as applications of *tincture of iodine*, *ichthyol* and *vaselin*, *lead-water*, *sublimated lanolin*, used by his predecessors in the Gothenborg Hospital since 1883, he concludes that the simple *vaselin* treatment should be the method of choice in erysipelas, since it produces as good results as any other without any irritating or toxic effects. (*Ther. Wochenschrift*, No. 6, 1896.)

Ferratin.—J. S. Perekhan (*Chicago Medical Recorder*, January, 1896), cites a case of anæmia in which the improvement under the use of *ferratin* was striking. The patient, a girl of 17, became anæmic after an attack of grippe, lost her appetite, etc. Condition on November 15th as follows: Face pale, of waxy color; lips and conjunctiva almost white; headaches, insomnia, constipation, shortness of breath, bad appetite, etc. Half-gramme (7¾ grains) doses three times daily, with hygienic regulation, caused improvement after first week, and gradually her appetite returned, headaches and insomnia disappeared, red color was

Ferratin (*continued*).

restored to lips and face, and within five weeks the blood-corpuscle count showed an increase from 2,100,000 to 4,150,000 per cubic centimetre. The author concludes that *ferratin* can be safely recommended as an hæmatinic remedy, suitable diet, hygiene, and exercise, however, not to be neglected.

Ichthyol in Ophthalmic Practice.—GERMANI finds that a 10- to 15-per-cent. ointment of *ichthyol* in *lanolin* is very efficacious in ciliary blepharitis, curing when the ordinary yellow ointment has failed. *Collyria* of 1 to 3 per cent. are also very useful in phlyctenular conjunctivitis and simple catarrhal ophthalmia. The drug was well borne, soon eased the pain in the eye, and accelerated the cure. The author has also made successful trial of *formol* as an ophthalmic antiseptic solution. The drug is used in solution of 1 to 2000 and the conjunctiva was found sterile twenty-four hours after its use. It was found useful in the treatment of phlyctenular conjunctivitis. (*British Medical Journal*, August 22, 1896.)

Lactophenin.—SENFFT (*Wiener med. Presse*, No. 50, 1896) reports a large experience with this drug in the treatment of children. He has used it as an antipyretic in pneumonia, bronchitis, typhoid fever, and diphtheria. It reduces the temperature promptly, and he reports no untoward effect on the stomach or depressing effect on the heart. Because of the last-named advantage he has substituted it largely for other antipyretics for children. To infants of 1 year he gives $\frac{3}{4}$ grain (0.045 gramme); at 4 years he gives one-fifth of the adult dose. (*Archives of Pediatrics*, June 1896.)

Mydrine.—This new mydriatic is a white powder, consisting of *ephedrine* and *homatropine* in the proportion of 100 to 1. A 10-per-cent. solution is recommended by CATTANEO as an excellent mydriatic, giving quicker results than any other agent. As the effects pass off very rapidly, it is valuable for diagnostic purposes. Mydriasis begins in eight seconds, reaches a maximum in thirty seconds, and maintains it for thirty minutes, the effect gradually ceasing in from four to six hours. (*Clinica Moderna*, June, 1896.)

Ovarian Extract after Castration.—DR. F. JAYLE has experimented on this subject, and concludes that ovarian opotherapy in castrated women causes the transitory or permanent disappearance of certain symptoms due to the removal of the organs, especially flashes of heat. It should be tried in cases of amenorrhœa and dysmenorrhœa due to ovarian lesions for which castration is often practiced. (*Presse Médicale*, May 9, 1896.)

Post-scarlatinal Dropsy.—Envelop the entire body in wet cloths and give internally 1 teaspoonful of *syrup of jaborandi.* When abundant perspiration has taken place, remove the wet cloths. Repeat the treatment daily until the dropsy has disappeared, which is usually within three days. (SCHMEY, *Allg. med. Central-Zeitung*, No. 1, 1896.)

Rheumatism.—Dr. Louis Faugères Bishop states that in the presence of an acute attack we should give *salicylic acid*, either as *salicin*, *oil of wintergreen*, or fresh *sodium salicylate*, in sufficient quantities to relieve pain and lower the temperature. The failures arise from insufficient quantity of the drug, either from lack of appreciation of the necessity or because some patients cannot stand it. Alkalies are generally believed to protect the heart, and are best administered as *sodium bicarbonate* in 1-drachm (4 grammes) doses as often as is practicable until the urine becomes alkaline. For chronic rheumatism 20 grains (1.3 grammes) of *salicin* every two hours should be given until relief of pain, then continued in the same dose three times daily. The digestion should not be overtaxed; carbohydrates, as potatoes, should be limited. Milk is a very good food, and *codliver-oil* is often extremely beneficial. (*American Journal of the Medical Sciences*, May, 1896.)

Sterilization of Catgut.—Hofmeister, of Tübingen, uses the following method: Roll the catgut without any other preparation in a single layer upon glass or metal plaques and knot the two ends. Immerse from twelve to forty-eight hours in a 2- to 4-per-cent. *formalin* solution. Wash by placing under running water for twelve hours, then boil from five to twenty minutes in water. Preserve in *absolute alcohol*, to which is added 5 per cent. of *glycerin* and 4 per cent. of *carbolic acid* or 1 per cent. of *sublimate*. (*Semaine Méd.*, June 6, 1896.)

Modification of Fowler's method: 1. Roll the gut very loosely on glass plates. 2. Place it in a jar in *absolute alcohol* and let it lie there for three or four days. 3. Place the plates in brass sterilizer (author's) just covered with *alcohol*. 4. Place the sterilizer in a saucepan containing cold water and keep it in for fifteen minutes after the water begins to boil. 5. Remove the gut and place it in a mixture of *glycerin* and *alcohol*, which should be changed every ten days. The sterilizer can also be used to render aseptic any substance which cannot be exposed to boiling water as tests, and also to resterilize the *glycerin* and *alcohol* in which the gut is stored. (Jellet, *Medical Press and Circular*, May 27, 1896.)

Tabes Dorsalis.—Ostankow has successfully used *oxalate of cerium* to shorten the gastric crises of tabes dorsalis. In doses varying from 0.15 to 0.50 gramme ($2\frac{1}{4}$ to $7\frac{3}{4}$ grains) three or four times a day, it caused the vomiting to decrease on the second day to six to eight attacks, instead of two hundred, as in some cases. The nausea and great thirst being thus lessened, a general improvement in the mental condition could be noted, and small quantities of nourishment could be retained,—an important point in these cases. (*Wien. klin. Woch.*, No. 24, 1896.)

Treatment of Surgical Tuberculosis with Iodine Injections.—Meynier reports twenty cases treated by Durante's method, which consists in the injection of a mixture of pure *iodine*, 1 per cent., and *iodide of potassium*, 10 per cent. The iodine may reach up to 5 per cent., but

Treatment of Surgical Tuberculosis with Iodine Injections.—*Continued.*
should not go beyond 0.03 gramme ($\frac{1}{2}$ grain) of pure iodine in the day. The injections are made daily, and should be intra-muscular, intra-glandular, or peri-glandular. In adenitis, as a rule, fifty injections suffice for complete treatment. The *iodine* has no specific action on the tubercle bacilli, but acts by augmenting tissue change and as an anti-fermentative. The author concludes that the cures obtained by Durante's method promise to be quite as satisfactory as those procured by surgical means. Children tolerate treatment very well. (*British Medical Journal*, June 20, 1896.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Report of a Case of Indigenous Parasitic Chyluria with Filaria Nocturna in the Blood, by **Frederick P. Henry**, Philadelphia, 1896.——Pan-Hysterectomy, or Total Extirpation of the Uterus by Abdominal Section, by **Christopher Martin**, Birmingham, Eng., 1896.——Société Française d'Otologie, de Laryngologie, et de Rhinologie. Rapports. 1896.——Annual Report of the Supervising Surgeon-General of the Marine-Hospital Service of the United States for the year 1895. Washington, D. C., 1896.——The Treatment of Typhoid Fever, by **George Duffield**, Detroit, Mich., 1896.——Torticollis and Adenoid Growths, by **J. E. Schadle**, St. Paul, Minn., 1896.——Cerebral Syphilis, with Report of Cases, by **William Hessert**, Chicago, Ill., 1896.——Du Traitement Chirurgical de la Surdité et des Bourdonnements, Bordeaux, **E. J. Moure**, Bordeaux, 1896.——Vaginal Hysterectomy. Twenty-one Consecutive Successful Cases, by **C. G. Davis**, Chicago, Ill., 1896.——An Electro-Therapeutical Cabinet, by **Franz Henel**, New York, 1896.——Prophylaxis in Infectious Diseases of Children, by **A. G. Wollenmann**, Ferdinand, Ind., 1896.——Neuritis Complicating Dislocations of the Shoulder and Elbow, by **M. A. Veeder**, Lyons, N. Y., 1896.——A Case of Diffuse Phlegmonous Gastritis, by **T. N. Kelynack**, Manchester, Eng., 1896.——Woman's Medical College of Pennsylvania, Forty-Seventh Annual Announcement, 1896.——Sudden Death and the Coroner, by **John B. Huber**, New York, 1896.——When and How to Curette the Uterus, by **Christopher Martin**, Birmingham, Eng., 1896.——De la Syphilis Conceptionnelle, par **G. Richard d'Aulnay**, Paris.——A Study of Some Fatal Cases of Malaria, by **Lewellys F. Barker**, Amœbic Catarrh of the Intestinal Tract, by **A. A. Young**, Newark, N. Y., 1896.——Contribution à l'Etude Biologique du Bacillus Viridis de Lesage, par **H. Cathelineau**, Paris, 1896.——The Relation of Gall-Stones to Primary Cancer of the Gall-Bladder, by **T. N. Kelynack**, Manchester, Eng., 1896.——Report of a Case of Prostatectomy and Encysted Calculi, by **J. A. Sutcliffe**.——The Syphilitic Chancre—The Soft Chancre, by **M. Crivelli**, Melbourne.——The Etiology and Pathology of Gastritis, upon which is Based Rational Therapeutics, by **Fenton B. Turck**, Chicago, Ill., 1896.——A Case of Lateral Deviation of the Trunk Produced by Adhesions of the Superior Gluteal Nerve to an Exostosis of the Ilium, by **M. Crivelli**, Melbourne, 1896.——Amputation of the Shoulder-Joint for Sarcoma, by **Thomas B. Eastman**, Indianapolis, 1896.——Bacteria of Conjunctiva and Relations to Ophthalmic Surgery, by **J. C. Foote** and **F. M. Wilson**, New York, 1896.——Il 3° dente Molare (Cosidetto "del senno") de'la mascella superiore, Studiate in 271 Crani, pel **A. Zuccarelli** e **G. Maucerl**, Naples, 1896.——De la Prothèse appliquée au traitement des Empyèmes de l'Antre d'Highmore, par **Simon Dunogier**, Bordeaux, 1896.——Extract of Thyroid and Bone-Marrow in the Treatment of Hodgkin's Disease, by **M. B. Herman**, Memphis, Tenn., 1896.

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

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AN AUXILIARY IN THE TREATMENT OF NEURASTHENIA.

In many cases of so-called neurasthenia the real morbid condition is an excessive production of uric acid in the system, the imperfect elimination of which gives rise to disturbances of various organs. The causes of this excessive formation of uric acid are not well understood, but there can be no doubt that errors in diet, lack of sufficient exercise, severe prolonged mental exertion, worry, anxiety, and other factors which interfere with metabolism play an important rôle in the etiology. A careful study of the etiology is, therefore, necessary in every case, in order to adopt the proper method of treatment. Attention to the diet and hygiene is of paramount importance. An ocean-voyage or a trip over the mountains ; the adoption of a diet consisting of light, nutritious foods ; abstinence from or restriction in the use of alcoholic beverages ; hydrotherapy, etc., are indicated. In the way of drugs, it seems rational to select a remedy which will act as a uric-acid solvent and eliminant. The best of these, according to recent experience, is lycetol, which is a combination of dimethyl-piperazine with tartaric acid. Lycetol administered in 5-grain doses three times daily will promptly increase the elimination of uric acid, as can be demonstrated by examination of the urine. It thus prevents the accumulation of this substance in the fluids of the body and the resulting disturbances of the digestive organs and the nervous system. As an auxiliary to hygienic and dietetic regulations, lycetol bids fair to occupy a prominent position in the therapeutics of neurasthenic cases, and its administration will, at least, facilitate the removal, from the body, of a morbific material which is responsible, to a great extent, for the disorders from which these patients suffer.

EUCAINE AS A LOCAL ANÆSTHETIC.

"Note on Eucaine as a Local Anæsthetic," by Robert Brudenell Carter, M.D., F.R.C.S.Eng., Consulting Ophthalmic Surgeon to St. George's Hospital.

"Dr. G. Vinci described eucaine as possessing the properties of cocaine as a local anæsthetic, but as being less toxic and as having no effect upon the pupil. The last statement seemed to me to be of practical importance, because a dilated pupil is an impediment to the performance of many operations upon the eye. It has long been my practice to neutralize the dilating effect of cocaine by a preliminary application of eserine, but this course is not entirely satisfactory. It is difficult to secure the precise degree of effect which is desired, while the eserine dilates the vessels of the iris and occasions free bleeding when they are incised. It also renders the iris-tissue comparatively rigid ; so that it is less easily drawn out of the anterior chamber. I obtained a supply of a 5-per-cent. watery solution of eucaine hydrochlorate from Mr. Rogers, of 327 Oxford Street, and used it last week for a cataract extraction, the patient being a woman. Before my arrival the nurse had applied a drop of the solution within the lower lid every five minutes for six times, and I found the eye perfectly insensitive. The pupil was unaffected and acted readily to light. There was scarcely any bleeding from the cut iris, there was perfect quiescence of the muscles, and there was no pain. I asked the patient whether she had felt anything, and she replied : 'I felt something moving about my eye, but it did not hurt me.' There was no pain afterward and healing was uninterrupted. I have since successfully used a single application of the same solution as a preliminary to the removal of a foreign body imbedded in the cornea.

"In the original paper it is said that eucaine has been successfully used in dentistry and laryngology, and that solutions may be injected hypodermatically without injury. My first experiments will induce me to use it again, and for tenotomies as well as for iridectomy or extraction. It is said that the solution above mentioned may be sterilized by boiling — again and again, if necessary — without undergoing decomposition or suffering any deterioration of quality." *The Lancet*, London, July 11, 1896.

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Selections from Society Proceedings.

GREAT BRITAIN.

BRITISH MEDICAL ASSOCIATION, CARLISLE.

Anæmia: its Varieties, Causation, and Treatment.—DR. FREDERICK TAYLOR, of London, in opening a discussion on this subject, confined his attention to the so called primary, or idiopathic, forms, which are two in number,—chlorosis and pernicious anæmia,—and detailed the differences between chlorosis and pernicious anæmea. These differences are so great that the diseases present nothing in common except cardiac murmurs and the pallor of the surface, though even here the skin in the one case is of a greenish and in the other of a lemon-yellow hue. Chlorosis is almost entirely confined to young females, while pernicious anæmia may attack either age or sex, but is specially prone to arise in middle-aged and elderly men. In the former the nutrition is not affected, constipation is frequent, and hæmorrhages rare; in the latter there is progressive wasting and not infrequently diarrhœa and hæmorrhages. The blood of the former shows very little diminution of red corpuscles, but a marked deficiency of hæmoglobin; while in the blood of the latter the red corpuscles may be reduced to 20 or 30 per cent. of the normal, but contain a greater proportion of hæmoglobin. Dr. Taylor then discussed the causes of chlorosis and referred to the following theories of its production: Disorders of menstruation, congenital narrowness of the aorta, disorders of the stomach (such as excessive acidity of the gastric secretions and low position, or proptosis, of the stomach), gastric ulcer with hæmorrhage, disorders of the intestine (such as habitual constipation), and the onset of puberty aggravating certain conditions peculiar to the female sex. The great frequency of the disease in the female sex was, he considered, the overwhelming fact in its history, and each of the preceding theories had to be considered in relation to this point in the etiology of the disease. The admission that chlorosis might occur in males and in females of middle age raised the question: What is the distinctive feature of chlorosis,—whether a special condition of the blood, or a peculiar tint of the patient, or the mere apparent causelessness of a curable anæmia? Following out the relation of the female sex to the cause of chlorosis, the influence of the corset was discussed in the production of ulceration and hæmorrhage, in the displacement of the stomach (gastroptosis), and generally in the production of pressure upon the upper part of the abdomen, where blood-forming organs, such as the liver and spleen, as well as the stomach, are situated. The improvement which follows rest in bed rather supports theories of this kind. To explain chlorosis by aggravation, at puberty, of natural changes, of the nature of defects, is to charge nature with imperfect adaptation of means to ends; at the same time the inferiority in corpuscles of female blood as compared with male is of interest. The influence of iron in its treatment was also considered in relation to the amount of iron contained in food as a rule and in the food of chlorotics.

Dr. Taylor next spoke of pernicious anæmia, the "idiopathic anæmia" of Addison, in which disease opinions have varied from time to time as to whether its fatality, or any special condition of the blood, or the apparent absence of cause is to be considered its essential feature. He thought that cases in which a definite lesion, such as hæmorrhage, was the starting-point, and yet anæmia persisted long after the cause had ceased to exist, were as difficult of explanation as entirely spontaneous cases, and as much deserved the epithet "idiopathic." He then referred to the two opposing theories of Dr. Hunter and Dr. Stockman, the former maintaining that it is a special form of disease, due to destruction of blood in the portal vein, probably as the result of ptomaines produced from micro-organisms in the bowel, in favor of which was the frequent accompaniment of intestinal dyspepsia; the latter arguing that it may arise from any kind of hæmorrhage, the characteristic features being due to absorption form minute hæmorrhages in various parts of the body. There were difficulties in the way of accepting either theory as complete. Dr. Taylor then considered splenic anæmia, giving a brief summary of a case which had occurred under his care, and shortly described the characteristics of the disease, the anæmia of chlorotic type, the enlarged spleen, the absence of leucocytosis, the hæmorrhages, and the progressive anæmia and emaciation, with death in from six months to four years. The nature of the disease was still very obscure. Banti had inclined to the view that it was a splenic form of Hodgkin's disease. It was important to recognize that it might be confounded with leukæmia unless the blood were microscopically examined. In the treatment of different forms of anæmia Dr. Taylor referred to the great value of prolonged rest in chlorosis and discussed the recent use of bone-marrow or its extract in pernicious anæmia. It had not been uniformly successful. If the change in the bone-marrow in pernicious anæmia were a return to an embryonic condition, it was an effort to remake blood in quantity, and the value of bone-marrow supplied from outside was less apparent. The essential element in bone-marrow was also not clear. The treatment of splenic anæmia by inhalation of oxygen, which had been used with varying effects in other forms of anæmia, and the value of the operation of splenectomy were also touched upon, the results of splenectomy in this disease contrasting very favorably with those obtained in leukæmia.

Dr. Byrom Bramwell, of Edinburgh, remarked that he looked on hæmorrhages from the stomach as a secondary condition, and not causal in any way. As regards the pathology of chlorosis, he thought it was due to something which prevented the absorption of iron in the intestines, combined with the strain of puberty. As regards its treatment, he advocated rest most strongly. The first principle he carried out was very large doses of iron, from 9 to 48 Blaud's pills in the day, administered after correcting any derangement of the stomach, and then to keep the patient in bed for three or four weeks. This method of treatment he had found almost invariably successful in a few weeks' time. He thought that more than one condition was often included under the term "pernicious anæmia," but those cases which corresponded to true pernicious anæmia were probably due to alterations in the bone-marrow. He advocated treatment by arsenic for this condition, but it should be continued for a long time and also after recovery.

Dr. Michell Clarke, of Bristol, wished to refer to the action of syphilis as a cause of anæmia. He referred to two cases he had recently had under his care which presented symptoms exactly like pernicious anæmia. He had tried treatment by oxygen in pernicious anæmia and found that it increased the corpuscles and the hæmoglobin.

Professor W. T. Gairdner, of Glasgow, as a clinical observer, was satisfied that there existed two opposite conditions of anæmia. He had not met with much success in what might be called the antiseptic methods of treatment, though one case of anæmia improved under salol; the case, however, afterward turned out to be latent tuberculosis. Arsenic was the most satisfactory remedy, in his experience, for pernicious anæmia. The pathology of pernicious anæmia was very obscure. The question was this: Is it a fault in hæmogenesis or in hæmolysis? And the answer seemed as far off as ever. He referred to the late Dr. Brackenridge, who met with remarkable success in the treatment of pernicious anæmia by repeated injections of small quantities of blood.

Dr. Affleck, of Edinburgh, spoke in favor of rest as the best therapeutic agent in chlorosis, but thought smaller doses of iron than Dr. Bramwell had used were equally necessary. He believed that pernicious anæmia was a definite disease and was sometimes amenable to arsenic. He confirmed the efficacy of transfusion of small quantities of blood and mentioned a case in point.

Dr. A. Haig, of London, wished to limit his remarks to the causation of chlorosis by uric acid. Chlorosis and other forms of anæmia are constantly associated with excess of uric acid in the blood; he had found that by controlling the uric acid the chlorosis was also controlled, and, finally, remedies which cleared the blood of uric acid also did the chlorosis good. On an anti-uric-acid diet the chlorosis disappeared without any drug being administered. The influences of age, diet, sex, climate, and various diseases on the occurrence of chlorosis were all explained on this view that chlorosis is the result of excess of uric acid in the blood.

Dr. Bulkley, of New York, thought that if in cases of anæmia the evacuations of the bowels were more investigated the disease could be more successfully treated. He had obtained good results from the administration of antiseptic remedies by the mouth.

Dr. Savill, of London, emphasized the extreme liability to error in the diagnosis of all forms of anæmia and especially pernicious anæmia. He did not wish in the least to doubt the entity of Addison's pernicious anæmia, but he had seen so many cases which during life had been regarded as undoubted cases of pernicious anæmia, and which had after death been shown to be cases of syphilis, latent carcinoma, and other conditions, that he had come to distrust many of the clinical observations unsupported by post-mortem examinations.

Dr. Bezly Thorne, of London, had found three features to be common to all cases of anæmia and chlorosis: (1) excess of uric acid in the blood, with more or less urinary inhibition; (2) a diminished vascular capacity; (3) dilatation of the heart, mainly, but not exclusively, of the right side. For treatment he recommended (1) exhibition of ferruginous preparations with or without arsenic, (2) diet and gastro-intestinal antisepsis by means of salicylate of bismuth and minute doses of some mercurial preparations, and (3) the Schott methods of exercises and baths, which greatly promote the metabolism of the body generally.

Dr. James Taylor, of London, exhibited a series of lantern-slides showing changes in the spinal cord associated with conditions of profound anæmia. These changes consist of a sclerosis not only of the lateral and anterior columns, but also of the posterior columns. According to the incidence of this change symptoms of lateral, anterior, or posterior sclerosis present themselves during life. In the latter case pupillary changes also occur. Dr. Taylor was inclined to think that these changes are not special to pernicious anæmia, but occur in any condition of profound anæmia and debility. The changes in the cord are strongly suggestive of a toxic origin, affecting, as they do, the spinal cord in a symmetrical manner, possibly with small hæmorrhagic foci also. The spinal cord in pellagra showed similar changes to those in severe anæmia.

Dr. W. B. Ransom, of Nottingham, gave a lantern demonstration of the histological changes in pernicious anæmia, based on eighteen cases, of which seven had previously had intestinal trouble. The deposit of pigment in many of the various tissues and organs of the body was well exhibited, though pigment was often absent from the liver and present in the kidney.

The clinical and pathological features of the first five of these cases pointed to an increased destruction of blood in this disease and also the absorption of poisonous substances from the intestinal canal. These facts pointed to a destruction of the blood-discs in the portal vein, though, on the other hand, it was curious that the pigment should in a few cases be absent from the liver. There was, Dr. Ransom thought, no evidence of special destruction of blood in the liver, spleen, and intestinal mucosa or in any one organ alone, but it seemed to have taken place all over the body. In his opinion this destruction was probably chiefly due to weakness of the young red cells newly and imperfectly formed in the long-bone marrow, and this disease was probably in its essence a defective hæmogenesis consequent on frailness in the red blood-cells. Furthermore, he came to the conclusion, in his researches, that pernicious anæmia was not one but several diseases.

Dr. William Russell, of Edinburgh, regarded Dr. Taylor's cases as showing non-essential accompaniments of anæmia. With regard to Dr. Ransom's cases he would insist that anæmic cases in which other lesions were present must be excluded from the category of pernicious anæmia, and that that term must be confined to cases in which no cause for the progressive anæmia was discovered post-mortem. No doubt there was a clinical difficulty, but it only confused issues to include cases where a cause for the anæmia was found. Even then it was possible that the cause might be varied. He had long maintained that it was a disease of blood destruction, and he was glad to find that Dr. Ransom's results tended to support this. The cause of the destruction was the point on which they were still ignorant; he was more and more disposed to regard it as probably due to a toxæmia, possibly by absorption from the intestinal tract; this view, to his mind, was becoming more forcible from the cyclical nature of some cases, their recoveries and relapses, with febrile manifestations. He had a case of that kind under observation at present, and he could in no way account for relapses, nor could he altogether account for recovery.

Dr. Frederick Taylor, in reply, said he was glad to find such a general agreement that pernicious anæmia was a specific disease probably due to increased blood destruction, though it might show several varieties due to the different causes of blood destruction. He agreed with Dr. Savill about the great care required in the diagnosis of anæmia, though he could not go quite so far as he did in excluding all clinical observations unconfirmed by necropsy. A great many latent conditions might exist without being evident during life, and he referred to the case recorded by Dr. Sidney Coupland and Mr. Pearce Gould in which the spleen was removed with great benefit for what was diagnosed as splenic anæmia; but subsequently the patient died from an intercurrent malady, and at the necropsy well-marked syphilitic disease of the liver of old standing was discovered.—*Lancet*, August 22, 1896.

SWITZERLAND.

Second International Congress of Gynæcology and Obstetrics, Geneva.

The Treatment of Eclampsia.—M. Charpentier, of Paris, in opening a discussion on this subject, stated that eclampsia was one of the most terrible accidents of pregnancy and labor, causing considerable mortality, both among mothers and children. Hence it is a constant subject of preoccupation for obstetricians, and the multiplicity of therapeutic measures is a proof that there is no real or sufficient remedy. This arises from the fact that the pathology of the disease is far from resting on a firm basis, and, until thoroughly established, it will be impossible to find a treatment which will give decisive results. Eclampsia, in truth, does not constitute a true morbid entity, the attacks characterizing it being only the manifestation of varying morbid conditions, from simple indigestion to hepatic, cerebral, or renal affections, of the most distinct and typical nature.

Though renal lesions, compression of the ureters, and albuminuria occupy the first place as causes, it must be borne in mind that there are a relatively large number of cases in which the symptoms and results are of the gravest character without the appearance of a trace of albumin in the urine, as well as cases in which the renal lesions are too insignificant to have been the only cause of death. We must also remember that eclampsia is a disease full of surprises for the physician. Who has not seen apparently benign cases end in death, and patients recover who, from the number of convulsions and their apparent gravity, seemed doomed to die?

From a practical stand-point the following conclusions may be adopted:

1. All pregnant women with albuminuria being liable to eclampsia, the urine should always be carefully examined, and, if a trace of albumin be found, absolute and exclusive milk diet should be at once adopted. This is the preventive treatment *par excellence* of eclampsia. In cases where there is œdema without albuminuria it is advantageous, if not absolutely necessary, to prescribe a milk diet.

2. When eclampsia has set in, if the patient is strong, vigorous, and greatly cyanosed, from 300 to 500 grammes (9½ to 16 ounces) of blood should be removed, chloral administered, and milk given by the mouth; if necessary, by means of the œsophageal sound.

3. The attacks themselves should be combated by chloroform inhalations, and diuresis favored by subcutaneous injections of artificial serum.

4. If the patient is more delicate, the symptoms of cyanosis but slightly marked, and the attacks less frequent, chloral only should be administered.

5. Whenever possible, we should wait until labor sets in spontaneously and allow delivery to terminate naturally.

6. If, labor being spontaneous, delivery does not terminate on account of too feeble or too slow uterine contractions, the forceps should be applied, or version followed by extraction, if the child is living; by cephalotomy, basiotripsy, or cranioclasis, if the child is dead.

7. Intervention should be delayed until the condition of the maternal parts is such that no violence will be done to them, and therefore attended with no danger for the mother.

8. Induced labor should be reserved for exceptional cases.

9. Cæsarian operation and *accouchement forcé* should not be considered as ordinary methods of treatment in eclampsia, but should only be resorted to in cases in which the death of the mother appears certain, and when all other measures have failed.

M. F. Halbertsma, of Utrecht, regarded the most important question in the treatment of eclampsia to be whether, at the end of pregnancy or the beginning of labor, it was best to wait or to bring on the delivery. In his opinion active interference is indicated when the prognosis appears to be extremely grave, on account of complete anuria, frequent and intense convulsions; when there is nothing to show that labor is about to commence; when there is reason to believe that a labor which has set in will be long and difficult, as in primiparæ of advanced age, with twin pregnancy or pelvic contraction. He would not advise abstaining from intervention until the pulse has become frequent and feeble, although even under these conditions such a course is sometimes followed by favorable results. At the end of pregnancy he would prefer the Cæsarian operation, but at the beginning of labor he would make deep incisions of the cervix by Dührssen's method.

M. L. Mangiagalli recommended the preventive treatment as combating the conditions which are the expression of the auto-intoxication of pregnancy. It is the more useful as these symptoms increase in intensity, and influences first of all albuminuria, particularly in primiparæ, as well as many nervous and gastric disturbances. Milk associated with intestinal disinfectants increases diuresis, improves the functions of the skin, stimulates the action of the heart, and is the sovereign prophylactic remedy in eclampsia. Medical treatment, whether represented by venesection, drastics, morphine, chloral, chloroform, veratrum viride, or diaphoretics, is essentially a symptomatic one, since it does not attack the cause of the disease. It constitutes, however, the only method possible in post-partum eclampsia, and is of value while waiting for conditions that will admit of obstetrical intervention. Venesection, followed by subcutaneous or endovenous injections of a physiological salt solution, is a method based upon rational considerations and supported by favorable clinical experience, though the latter is not yet sufficiently great to permit of a just estimation of its value. Rapid evacuation of the uterus is the most important point in the treatment of eclampsia, but it is necessary to take into account, on the one hand, the gravity of the case, and, on the other hand, the dangers of intervention. In intra-partum eclampsia it is a good rule to terminate delivery when the conditions permit it, preparing the passages by deep incisions of the cervix when this is obliterated and dilatation is insufficient.

The following measures are indicated in the eclampsia of pregnancy: Induction of labor by rupture of the membranes; the use of morphine, chloral, or veratrum viride in large doses, the latter being the more efficacious when it is administered near the beginning of the eclampsia. If the case is serious, the danger menacing, and if, in spite of these measures, it is thought unwise to temporize until obliteration of the cervix occurs, dilatation of several centimetres, if the cervix is shortened and softened, will be better in most cases than the deep incisions recommended by Dührssen. In cases of the same category, but in which the cervix is not softened, or where there are conditions rendering this plan difficult or contra-indicated, Cæsarian section may be justified, especially when the fœtus is alive and at term. All surgical intervention should be made under deep chloroform narcosis.

Professor Veit, of Leyden, stated that it was impossible to establish a single method of treating eclampsia. A great number of cases recover under any treatment. Systematic treatment by large doses of morphine appears to give the best results. What appeared to him the most advantageous plan was to prudently hasten the labor, rupture the membranes, deliver the patient after complete dilatation of the soft parts, give large doses of morphine to diminish the number of attacks, avoid the administration of remedies by the mouth to unconscious patients, and produce diaphoresis by exterior measures.

Dr. John W. Byers, of Belfast, gave the following as his treatment: Hypodermatic injections of morphine should be given. The patient should be made to lie on her side in order to prevent the passage of fluids into the larynx and the lungs, pulmonary œdema being a frequent cause of death in eclampsia. Care should be taken that the patient does not injure herself, that she be kept warm, well purged, that no fluids be given her. and that she have a hot or vapor- bath between the attacks, if conscious. As regards obstetrical treatment, if labor has not commenced the convulsions should be treated without exciting the uterus. If labor has set in and the period of expulsion has arrived, chloroform should be given and delivery rapidly terminated. In the period of dilatation, if the cervix is dilatable, delivery may be hastened by means of hot douches and the application of Barnes's or Champetier de Ribes's dilators; if the cervix is rigid, it is best not to interfere. As prophylactic measures, rest, milk diet, purgatives, and hot baths give the best results.

Professor Parvin, of Philadelphia, stated that he had had the greatest success with veratrum viride, which goes directly to the cause of the eclampsia,—that is, the poisoning of the blood. The remedy notably diminishes the frequency of the pulse, and we know that convulsions rarely occur when the pulse is kept at or below 60. The principal effects of the drug are to increase the activity of the cutaneous functions, to lower the temperature, and to increase urinary secretion. Of 100 patients treated by veratrum viride in his practice, 92 were saved.

M. Tarnier, of Paris, in the preventive treatment, prescribes a milk diet not only to all patients with albuminuria, but to any pregnant woman presenting nervous symptoms which might be attributed to the toxicity of the blood. An absolute milk diet is indispensable, with the addition of 3 or 4 grammes ($\frac{3}{4}$ to 1 drachm) of chloral daily. His curative treatment is based on the theory that eclampsia is due to the toxicity of the blood-serum, as shown by his personal researches. To diminish this toxicity he combines milk diet with general venesection and the use of drastic purgatives. If the patient cannot swallow milk, he uses the œsophageal sound. His plan of treating an attack of eclampsia is: (1) copious bleeding of the arm; (2) drastic purgatives; (3) chloroform, chloral; (4) milk diet.

UNITED STATES.

American Neurological Association, Philadelphia.

Does Antisyphilitic Treatment Prevent the Occurrence of the Diseases of the Nervous System which are Considered Syphilitic in Origin?—In a statistical study of this subject, Dr. Joseph Collins, of New York, pointed out that certain diseases of the nervous system occur sequentially to syphilis with such frequency that they are rightfully looked upon as syphilitic in origin. These diseases are tabes, general paralysis, syphilitic spinal paralysis, and such exudative conditions as cerebral thrombosis.

On few questions is the medical profession so divided as on the curability of syphilis. Syphilographers who see the cases early contend that the disease is a very curable one, while neurologists who see the late manifestations have quite opposite convictions. By "cure" he understood that the disease had been put to an end by the application of remedial measures. He recorded the results in a certain number of cases of nervous diseases of syphilitic origin taken from the case-books of Dr. Dana and himself, from the ambulatory material of the Post-Graduate Clinic, and from the nervous wards in the city hospitals, with a view of determining the frequency of confessed syphilitic infection, the time during which first treatment was given, the time which had elapsed between specific infection and the appearance of the nervous disease, and particularly whether or not such treatment, when given with a moderate degree of thoroughness, prevented the occurrence of the diseases mentioned, as contrasted with cases in which there had been very little treatment.

In 10 hospital cases of tabes, in which there was a history of antecedent syphilis in each one, the average duration of treatment was 3⅓ months, and the average time elapsing between specific infection and tabes was 13 years. In 30 private cases in which there was a history of syphilitic infection the average age when infected was 25 years; average duration of treatment, 20 months; average time between infection and tabes, 14 years. In 12 hospital cases taken from a different source specific infection was admitted in 10 cases; average age of the cases when infected was 26 years; average time between syphilis and tabes, 10½ years; average age when tabes developed, 40 years; average term of treatment, 7 months.

In 20 dispensary cases the average term of treatment was approximately 3 months, the average time elapsing between the initial lesion and the first symptom of tabes was about 10 years, and the average age in which tabes developed was 43 years. In 26 cases of tabes from private and public sources, in which syphilitic infection was denied, the average age of the cases when tabes developed was 42½ years. The age at which the disease developed in hospital cases was 40½ years; in private cases, 39 years; in dispensary cases, 36 years, and in cases without history of syphilis, private and dispensary, 42½ years.

There is practically, then, very little difference in these four classes of patients as to the time when the symptoms of tabes first showed themselves. In the private cases in which thorough treatment was carried out it occurs somewhat earlier than in hospital cases, where the average length of treatment was a little over 3 months. More striking yet than this are the statistics of 23 cases in which there is no history of syphilitic disease. Granting that tabes is a post-syphilitic disease, here are 23 cases in which there is no antisyphilitic treatment; yet these are cases in which tabes did not develop until after the forty-second year,—the most advanced age of any of the cases. In the records of 100 cases of tabes 75 per cent. gave a distinct history of syphilitic infection or such secondary histories as would warrant even the most skeptical to include them as syphilitic.

In 25 cases of hemiplegia in which syphilis seemed to be the cause of attack, the time elapsing between the initial lesion and the hemiplegia was about 6 years. Treatment which had been given at the time of the initial lesion averaged about 1 year. In the cases of syphilitic spinal paralysis the average time between the infection and the nervous disease was about 4½ years, and the average duration of antisyphilitic treatment in these cases was 13 months. Of the 14 cases of general paresis there was a distinct syphilitic history in all except 4 cases. The average duration of treatment was 1 year. In these cases the average time which elapsed between the primary lesion and the general paresis was 14 years.

The conclusions arrived at were as follow:—

1. Exudative and degenerative diseases due to syphilis are most liable to show themselves at the end of the third and beginning of the fourth decade of life.

2. Thorough and prolonged administration of antisyphilitic remedies during the activity of the virus does not seem to materially prolong this time-limit.

3. active and prolonged antisyphilitic treatment does not seem to prevent the development of such diseases as locomotor ataxia or general paresis. This is true of degenerative disease, though treatment may, however, have some effect in preventing the exudative disease of the nervous system, such as syphilis of the spinal cord, diseases of the blood-vessels, etc.

4. Cases of tabes and general paresis, in which syphilis is confessed and in which treatment has been most desultory and incomplete, are not more liable to the early development or to the severe manifestations of either of those two diseases than those in which the treatment has been all it should be.

5. The administration of antisyphilitic measures in the most approved

way does not fulfill the requirements of cure, and syphilis is often an incurable disease.

Dr. B. Sachs, of New York, agreed, to a limited extent, with the conclusions that Dr. Collins had drawn, and was willing to do so to the extent of saying that in a very large number of cases no treatment will suffice to prevent the development of tabes or general paresis. To disprove Dr. Collins's views it would only be necessary to take the statistics of those who have had the early manifestations of constitutional syphilis, and then note whether those who have or have not had special treatment develop nervous symptoms later. If Dr. Collins could prove that antisyphilitic treatment under these circumstances has had no effect, his conclusions would be more satisfactory. There are certain facts, however, which point indubitably to the influence of antisyphilitic treatment. There is always some doubt about the effect of the initial treatment in these cases that are developed twenty years after the infection. He would hesitate to adopt Dr. Collins's conclusions because of the frequency of serious affections of the nervous system developing within six months or a year, in the absence of antisyphilitic treatment. It is an unfortunate circumstance that a very fair proportion of them develop general paresis or have early apoplectic seizures.

Dr. Knapp, of Boston, in spite of Dr. Collins's statistics, would not decide to let a patient in the early stages of syphilis go without treatment. It is, of course, true that in many of the cases of syphilis of the nervous system that we see there has been a long and thorough course of treatment, sometimes at the hands of the best syphilologists, before the outbreak of the nervous symptoms, but, in spite of such cases and in spite of these statistics, based upon a comparatively small number of cases, it is still a question whether treatment has not some value in preventing the later nervous disease. In very many cases of syphilis of the nervous system we can get a history of very little except the initial lesion; so that he had been led to feel that, if the secondary cutaneous and bone lesions were severe, there was less likelihood of the development of nervous symptoms.

Dr. Osler, of Baltimore, was strongly of the opinion that the best guarantee for an immunity against the late effects of syphilis is a thorough, systematic, and prolonged treatment in the initial stages of the disease.

Dr. N. E. Brill, of New York, asked Dr. Collins how he reconciled the fact that antisyphilitic treatment not infrequently cures tabes and paretic dementia of syphilitic origin with the conclusion drawn from his statistics that antisyphilitic treatment does not prevent the development of these diseases.

Dr. Preston, of Baltimore, called attention to the effect of treatment upon syphilitic endarteritis. Unquestionably a certain proportion of the chronic cord-lesions following syphilis are due to syphilitic disease of the arteries and a consequent cutting off of nutrition. His own experience led him to believe that prompt and thorough treatment of the syphilis distinctly lessens the probability of an involvement of the blood-vessels.

After this change in the arteries has become marked it is very unlikely that antisyphilitic treatment is of any advantage.

Dr. Hugh T. Patrick, of Chicago, said that, while the paper demonstrated that the period between the initial sore and the appearance of tabes or dementia paralytica is about equal in the well- and badly- treated cases, it did not prove that treatment has no effect in preventing these affections. In other words, when these diseases do follow syphilis, the period of incubation is uniform. They are not, strictly speaking, syphilitic, but post-syphilitic affections, and are to be sharply discriminated from syphilis. There are certainly other causative elements entering into their evolution besides specific infection, and he could easily imagine that antisyphilitic treatment might prevent their occurrence, but not alter the period of incubation. Regarding the later occurrence of true syphilitic lesions, it is, as Dr. Gray has said, almost impossible to know if a patient has had proper treatment. Continued specific treatment is not necessarily adequate treatment. Dr. Patrick had recently had a patient who received average doses of mercury from the day of appearance of the primary sore until the appearance of decided symptoms of cerebral syphilis, six months later. Simply a more vigorous specific treatment caused all the symptoms to disappear as it would have prevented their appearance. The ordinary routine treatment of syphilis abroad, especially in Germany, is much more vigorous than in this country, but is kept up for a much shorter period, and it seemed to him that the later manifestations of the disease, as well as the post-syphilitic diseases, are more frequent there than here.

Dr. F. X. Dercum, of Philadelphia, said that it was hardly fair to judge of the efficacy of antisyphilitic treatment by selecting two diseases such as locomotor ataxia and paresis. If the inquiry were to embrace all forms of nervous syphilis, especially true nervous syphilis, the result would be different.

Dr. J. Collins, in closing the discussion, said: "I have advanced no individual ideas nor theories; I have simply taken statistics without juggling them, and have drawn apparently warrantable conclusions. If we are not permitted to do this, of what service are our histories? What does it profit us to record cases if we are not permitted to make use of the experience thus gained? I must say that I have had a change of heart in the matter of diseases of the nervous system caused by syphilis during the last year, and particularly since I have been studying these cases. Formerly, I was fully convinced that the views advanced by Dr. Osler were correct, and I am now ready to say that I believe that I was holding an untenable view. In answer to one question I wish to say that, if a patient came to me with general paresis, I know of no power that could make me administer to him large doses of mercury or iodide of potassium with the idea of combating a remotely anterior syphilis. I am not in sympathy with the plan of taking cases of tabes and beginning a systematic administration of mercury. I am convinced, from my short experience, that this treatment does no good and often does harm. If the experience of others show that they have benefited their patients, they owe it to us to publish their views.

Where the statistics are detailed, I have gone somewhat into the treatment. I am not aware that there is any great amount of discrepancy as to what constitutes the proper treatment of syphilis at the present day. I thought all those who had studied the disease had come around and consented to the belief that the proper treatment is the administration of mercury kept up from one and a half to three years. There are few who teach that the administration of iodide of potassium is of any service, and it is only in the exudative condition that it does good. It has no effect upon the treatment. I consider the cases of acute tabes and acute general paresis which have been mentioned not as cases of true tabes, quite the contrary. They are devoid of any of the true symptoms and are really cases of pseudotabes. They are associated with a slight exudative lesion in the columns of Burdach and Goll, or the posterior roots. I wish to repeat that, except in closing this discussion, I have advanced no theories or opinions, but have simply put forward the single arguments taken from my case-book. After studying these cases and working them over as carefully as I could, I became convinced that the conclusions which have been given us were not those that could be backed up by real experience. I could quote individual cases where the patient had received good treatment and yet had developed lesions which are called post-syphilitic. My experience agrees with that of Dr. Knapp in that those who have the severe tissue manifestations of syphilis are less liable to later sequelæ, while those who have had syphilitic infection mildly frequently develop tabes and paresis. I have not considered gummata. When the pathology of the latter is understood, then I think it will be shown, as it has already been shown to my satisfaction, that the gumma is more of an acute syphilitic manifestation than a degenerative, and should be amenable to mercury. If I were so unfortunate as to contract syphilis to-day, I should want mercury; but if I develop lesions which predicate previous syphilis twenty years hence, I beg to be spared mercury."—*Journal of Nervous and Mental Diseases*, August, 1896.

JOHNS HOPKINS HOSPITAL SOCIETY, BALTIMORE.

The Abortive Treatment of Acute Suppurative Adenitis of the Groin by Pressure Bandage.—In a paper on this subject DR. A. BRADLEY GAITHER states that the frequency with which the complication of acute suppurative adenitis of the groin is present in cases of urethritis and chancroid and the very unsatisfactory results of treatment instituted to check the process should make any procedure which holds out even a fair chance of success most welcome. When used for abortive treatment, applications of iodine, mercurial ointment, belladonna ointment, etc., have given practically no results, while injections of solutions of bichloride of mercury or carbolic acid are painful and liable to set up a great deal of inflammation. There is also the risk of infecting the bubo, the contents of which are always absolutely free from germs. In the hands of some operators gratifying results have been obtained from injections, but, as a rule, they have been discarded as unsatisfactory. In fact, all the abortive methods having been found wanting, it has become more and more popular with surgeons to abandon such treatment altogether and to endeavor to bring the condition to an operative stage as soon as possible.

Dr. Lydston advocates "the early and complete extirpation of all buboes." He claims that "when suppuration has begun in the glands, and this suppuration begins early, even as soon as the third day, the inflammation extends to the periglandular tissue; and then the case becomes long and obstinate from the continued suppuration."

Dr. Edward Martin says that "in the treatment of bubo the best results, in the long run, would be obtained by immediate incision of the glands as soon as they become markedly inflamed and closure of the resulting wound by suture. It is a good rule to attempt the abortion of a bubo not longer than three days. If no good results follow in this time, suppuration will almost certainly occur."

Such had been the author's opinion before using the pressure-bandage abortive treatment, but, on account of the results obtained from a series of cases, he would now advise putting on a pressure bandage, regardless of the age of the bubo, if suppuration has not advanced to such a degree as to bring the case practically to the operative stage.

The bandage is applied as follows: A piece of cotton as large as the fist is folded in on itself again and again until it has the shape of the bubo, and when placed on it does not completely cover it. This is carefully adjusted, and a wad of tightly-compressed cotton as large as a cocoa-nut placed over it. Small pieces of cotton are also used on the inner and outer surfaces of the thigh to prevent chafing. A very tight spica bandage is then put on. The amount of pain experienced by the patients varied greatly. In some cases the pressure did not seem to increase it at all. In fact, the relief of pain has been, in most cases, remarkable. One man with a large bubo in each groin had suffered a great deal and had been unable to work for three weeks previous to applying for treatment. Two days after the double bandage had been applied he returned to his work, that of a laborer, and continued the same without interruption while the buboes were being aborted. In almost every variety of treatment for bubo the point insisted on is rest in the dorso-decubitus position. While wearing the pressure bandage this is by no means imperative, though it is to be preferred. If the bandage remained in position twenty-four hours, even if the gland went on to suppuration, the pain would be diminished.

In the series of cases reported, which were treated in the genito urinary clinic of the Johns Hopkins Hospital Dispensary, the bandage was used regardless of the condition of the bubo or the apparent hopelessness of success. Eighteen cases were treated, 4 of which were practically in the operative stage when the bandage was applied, and 3 of the 4 showed no improvement. In 2 cases the men were unable to keep the bandage on more than a few hours, saying that the pain, already great, became unbearable. Of the remaining 12 cases, the bubo was aborted in 9, including 2 which seemed to be so far advanced as to leave no chance of success. The earlier the bandage was applied, the better was the termination, and, if treatment were begun before any sign of suppuration could be made out, a satisfactory result was obtained in more than 85 per cent. of the cases.

In estimating this percentage it must be borne in mind that in a certain proportion of cases a bubo will subside while we are doing our best to hasten suppuration. The author recalls the case of a man who had a bubo in each groin, one of which had reached the operative stage, while the other was not quite so far advanced. In order that both might be incised at the same time, he was advised to apply a poultice and come back in three days. He kept poultices continually on each bubo, and on his return it was found that suppuration was being checked on both sides, and eventually he recovered without operative interference.

In several instances the tightness of the bandage caused œdema of the penis by interference with the circulation, which readily subsided when pressure was relieved. In a case of double bubo, when the bandage was left off for one day on account of œdema, there was, in that time, marked evidence of a return of suppuration, which had apparently been checked.

The bandages were renewed in from four to eight days, and the patients were able to continue work without inconvenience. If the abortive treatment did not prove successful, the buboes were much larger than they would probably have been had they not been kept under pressure.

In one case, in which the bubo was incised under ether after the pressure bandage had been worn eight days, the glands were found hard, matted together, and without suppuration at the top, but at the very bottom some pus was found. It seemed that the suppurative process had been checked from above downward and had almost stopped. It is probable that, had the bandage been persisted in a few days longer, there would have been no necessity for an operation and absorption would have taken place.

It can be said in favor of the pressure-bandage treatment for acute suppurative adenitis of the groin that (1) it is safe; (2) pain is, as a rule, diminished after twenty-four hours; (3) it does not prevent the patient from pursuing his usual occupation; (4) it gives a high percentage of successful cases.—*Bulletin of the Johns Hopkins Hospital*, July, 1896.

Pertussis.—JOSIAS, in his new work, *Thérapeutique Infantile*, recommends the use of thymol instead of carbolic acid as a spray in this disease. A vessel containing the following solution is placed over a small night-lamp in the room and allowed to evaporate: ℞ *Thymol*, 10 grammes (2½ drachms); *alcohol*, 300 grammes (9½ ounces); *water*, 700 grammes (22½ ounces). At the Trousseau Hospital an alcoholic solution of thymol and menthol is used several times a day for spraying the rooms set apart for whooping-cough cases. A vapor-atomizer and the following formula are employed: ℞ *Thymol*, 6 grammes (1½ drachms); *menthol*, 6 grammes (1½ drachms); *alcohol* at 90°, 120 grammes (4 ounces). A tablespoonful in the atomizer, which has been previously filled with water.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Italia.

Prof. F. Massei,
Redattore Corrispondente per
le Laringologia e
Rinologia.

Si prega di mandare tutti i giornali, libri, stampe, etc., sulle suggetti sopra nominate che vedono la luce in Italia al

Prof. F. Massei,
4, Piazza Municipio,
Napoli.

Alarming Hæmorrhage After Tonsillotomy.—Dr. B. Piergilli describes a case of this kind in a young man, 20 years of age, who underwent double tonsillotomy without accident. Seven hours later a severe hæmorrhage occurred, but was controlled, returning, however, four times within five days, and assuming such an alarming nature that it was decided to resort to ligature of the right common carotid. The operation was performed by Prof. Durante, and the immediate symptoms following (difficult speech, stupor, and convulsions) soon completely disappeared. Two months later the young man had so improved as to be pronounced well.—*Arch. ital. di Otol., Rin., e Lar.*, fasc. 3, 1896.

Supernumerary Tooth in the Nose.—Dr. G. Chincini observed, in Prof. de Rossi's clinic, a woman, 23 years of age, who complained of nasal symptoms, with fetid discharge, crusts, etc. By means of a forceps there was removed from the nasal cavity not a piece of bone, as was thought at first, but a molar tooth with two roots blackened from gangrene. The author believes that this tooth was developed in the nose, its germ being present there before the palatine fissure was closed. The teeth in the superior maxillary bone had all the characteristics of permanent teeth.—*Ibid.*

Endothelioma of the Nose in a Woman with Caseous Rhinitis.—Dr. F. Acerbi presents an histological study of a tumor spontaneously expelled by a woman 20 years old, suffering from the so-called rhinitis caseosa, in Professor Massei's clinic. The growth was decided to be an endothelioma, benign in nature and but rarely observed, especially in the nose. The author states that it is the first of the kind recorded, after Dansac's case, though differing from the latter, which originated in the septum, and endothelium of the blood-vessels, while in his own case it took its origin from the turbinate and lymphatic lacunæ.—*Arch. ital. di Lar.*, July, 1896.

Amyloid Growths in the Larynx.—Dr. G. Martuscelli publishes an interesting study of two cases of small laryngeal growths originating from the vocal cords and operated on by Professor Massei. There was not present in these cases—the histories of which are given—the usual amyloid degeneration of the walls, glands, and epithelium. The amyloid growths were of different forms and sizes, and there was but little connective tissue and but a small number of leucocytes. In one case the amyloid substance occupied a central position, there were a few connective-tissue fibres in bundles, and several blood-effusions. No cellular capsules containing nuclei and giant-cells were observed. Hence the conclusion that this latter is a special modification of albumin, and that it is more rational to ascribe it to a local degeneration due to a local cause, rather than as connected with the amyloid degeneration, as Leber believes. The cases are also interesting as showing that instead of being multiple, as in all previously recorded cases, these growths may occur singly and may resemble cystic fibromata. If microscopical examination were always resorted to, amyloid tumors might not prove to be so rare as they are now supposed to be.—*Ibid.*

Norway.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME. PÄDIATRIK, OBSTETRIK, GYNÄKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter etc., der adkomme i Danmark bedes sendt til

DR. LEVISON,
Norrevoldgade, 13,
Köbenhavn.

A New Bread for Diabetics.—IVAR BANG, by triturating only the superficial layer of the grain after preliminary decortication, has succeeded in obtaining a flour extraordinarily rich in nitrogen, which can easily be made into bread. This bread resembles the ordinary home-made bread, but contains almost twice as much albuminoid substance. He made experiments with it on a prisoner condemned to a diet of bread and water. After two periods of five days each, with an intermission of five days in which he was given ordinary food, the author found that the new bread was absorbed three times more readily than black bread. It may therefore be employed to advantage in the diet of diabetic patients.—*Norsk. Mag. f. Läger.*

The Protozoa of Animal Vaccine.—VEDELER has studied the protozoa of animal vaccine by inoculations into the cornea of the rabbit, observing the result two, three, five, and seven days afterward. The inoculation always produced an hypertrophy of the epithelial cells, and at the same time a considerable hyperplasia, commencing on the surface, but infiltrating the depth of the cornea after the seventh day. According to the author, the development of the protozoa is at first similar to that described by Pfeiffer, while later it contains a great many nuclei, lancet-shaped, and each containing a tiny nucleus. The author has also examined human vaccine, but found only round, shining spores about the size of a micrococcus.—*Ibid.*, p. 486, 1896.

Beriberi.—ROLL and LAACHE observed two cases of beriberi in Norwegian sailors who had returned from countries to which this disease is peculiar. Roll believes that the infection is due to the drinking-water. The two sailors had spent three months in a port where beriberi was endemic, but no one on board the vessel contracted the disease. During this time they used drinking-water brought from Europe. A month after the vessel had been supplied with water from this port, and when out at sea, the disease showed itself on board.—*Ibid.*, p. 509, 1896.

Appendicitis.—FRANCIS HARBITZ has studied the pathological anatomy and etiology of appendicitis, from a large number of case-records from the "Rigshospital" at Christiania. Among these he found 17 cases of simple appendicitis, but often recurrent, giving rise to strictures of the appendix, to perforations, encysted abscesses, etc. Ordinarily the contents of the appendix consisted of a puriform liquid, sometimes mixed with fæcal matter, and in 4 cases containing calculi. There were 6 cases of acute appendicitis necessitating operation, and about 30 autopsies of perforating appendicitis in various stages of development. The author believes the disease to be caused by the microbes of the intestine. He does not admit that calculi can alone cause appendicitis. Fæcal calculi, 14 cases of which were recorded in his list, form in the appendix by the desiccation of fæcal matter containing foreign bodies, such as fruit-stones, etc. In 17 cases the author examined the contents of the appendix from a bacteriological standpoint. Two cases of encysted pus proved to be sterile; in 2 the staphylococcus pyogenes aureus alone was present and in 1 the bacterium coli communis. In the remainder of the cases there was a mixed infection and the cultures showed staphylococci, diplococci, more rarely streptococci, and very frequently the bacterium coli communis. He also noted the presence of small rods, staining by Gram's method and resembling morphologically the bacillus of diphtheria.—*Ibid.*, p. 461, 1896.

Petroleum Poisoning.—AXEL JOHANNESEN treated a child, aged 2 years, who had accidentally swallowed some petroleum. The quantity taken could not be determined. In spite of prompt and appropriate treatment, the child became somnolent and died within three hours. The post-mortem examination showed atelectasis and cyanosis of the lungs, a small quantity of fluid in the pleural cavity, and a marked odor of petroleum in all the organs.—*Ibid.*, p. 565, 1896.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandlingar, monographier a. s. v. torde ett exemplar benäget öfversändas till

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Treatment of Obliteration of the Nasal Orifice of the Lachrymal Duct.—H. ALLAND, in discussing this subject, states that the diagnosis of obliteration of the duct is best made by flushing the canal with some liquid, when, if a valve or obstruction is present, the liquid will not pass through the canal. If a probe passed in at the ocular end of the canal can be touched from the nasal side, the presence of a valve is unlikely. A diagnosis should not be based on a single examination, as the obstacle may be of only temporary duration. If found to be permanent, it may be treated by means of an incision through the median wall of the nasolachrymal duct, toward the inferior nasal meatus, the duct being cut by means of a scalpel introduced through the nostril. The author has also invented an instrument for the purpose, from which he has had good results, the inferior orifice of the duct remaining open two months after the operation.—*Upsala läkareförenings forhandlingar*, vol. i, Nos. 6 and 7.

Tumor Near the Central Gyri.—H. Köster observed a case of this kind in a bookseller, 46 years of age, who, twenty years previously, had had a soft chancre without further symptoms. Without any preliminary illness he was suddenly seized with a fit, with spasmodic jerking of the right arm and leg, beginning in the hand. He fell, but a minute afterward was able to walk home. Ten days later there was a similar attack without unconsciousness. He then remained well for about three months, presenting no symptoms whatever, when he suddenly had two similar fits, with spasms, being unconscious for two or three hours after the last attack. Köster noted undisturbed intelligence; absence of headache, nausea, or dizziness; slight paresis of the inferior zone of the right facial nerve; paresis of the right arm and leg, and deviation of the tongue to the right. There was no ataxia, sensibility was normal, and the patellar reflexes strong, especially on the right. The paresis gradually increased and rigidity of the leg, with clonus, set in; the fits recurred, with jerking in the right arm and leg and in the territory of the right facial nerve, and paralysis finally became complete on that side, the inferior branch of the right facial nerve and the hypoglossal nerve being involved. Papillary stasis was not noticed for three months, but it was then quite marked. Toward the end the patient's mental faculties became gradually impaired and he suffered from violent delirium and vomiting. Trephining over the central gyri failed to reveal the presence of a tumor. A considerable prolapse of the brain occurred and for a short time after the operation the papillary stasis decreased and almost disappeared for a short period; but the patient gradually grew worse and died. The post-mortem examination showed a tumor situated partially in the prolapsed portion of the brain and separated from the surface by a mass of altered cerebral substance 0.5 centimetre in breadth. On the inner surface the tumor entered the occipital fissure and occupied a great part of the centrum ovale. Microscopically the growth was found to be a round-celled sarcoma.—*Ibid.*

Laryngeal Stenosis.—A peculiar case of laryngeal stenosis, with fatal issue, is reported by Backlund. The patient, a child 20 months old, was received into the Goteborg Hospital for Infectious Diseases on account of severe symptoms of croup. Tracheotomy was performed, but the child died. At the post-mortem examination the author found the needle of a fir-tree immediately beneath the rima glottidis. It was 1.5 centimetres long. The lungs were atelectasic and there was some broncho-pneumonia. —*Goteborg läkaresallskaps forhandlingar*, vol. i, p. 1.

Foreign Body in the Larynx.—Alarik Lindh describes the case of a child, 8 months old, who, while playing with a pasteboard box, swallowed a corner-clip of tin bent rectangularly. Lindh cut through the cricoid cartilage and the first tracheal ring and dilated the incision, and then pushed up the foreign body into the pharynx by means of a sponge-holder with a small sponge attached. He then introduced a silver cannula, which he removed four days later, the child recovering.—*Ibid.*, p. 9.

Incomplete Inversion of the Uterus, with Fatal Issue.—Neuman describes the case of a primipara, aged 26 years, with viable fœtus, who had suffered for eighteen hours from pains without free interval. The uterus, firmly contracted about the fœtus, showed, on the right lower portion, a little above the os pubis, a projection as large as a fist. The head, forced down into the pelvis, was in the vertex position. There was severe albuminuria with œdema. The pains were regulated by means of morphine in doses of 0.015 gramme ($\frac{1}{4}$ grain), and eight hours later a living child was delivered spontaneously. Immediately afterward the patient's features became distorted, she became restless, complained of severe abdominal pains, and suffered from violent metrorrhagia. A polypoid tumor the size of a child's head, to which the placenta was firmly adherent, presented in the vagina. The placenta was detached, but the tumor, which was the partly-inverted uterus, could not be returned to its place, even under chloroform narcosis, owing to contraction of the inverted segment of the cervix. Collapse and death followed.—*Ibid.*, p. 48.

Clinical Notes and Lectures.

A Simple Operation for Ectropion.—In operating on cases of ectropion, Dr. Kenneth Scott, of Cairo, Egypt, has found that no absolute reliance can be placed on the exact ultimate effect which will be produced by either of the varieties of operation usually employed,—namely, the plastic skin ones and those depending on the action of artificial cicatricial bands. Owing to there nearly always being some giving and stretching of tissues after the operation, more or less considerable in degree, the good effect which should be obtained by these operations is thus often very greatly neutralized. On the other hand, if, in order to allow for the ultimate partial failure so often caused in this way, an overeffect is intentionally produced at the time of operation, some temporary deformity is naturally caused, which unfortunately, in not a few cases, remains permanently. For this reason he has for several years employed a form of operation the effect of which is dependent on the firmer tissues of the eyelids,—tarsal cartilage and orbicularis palpebrarum muscle. He uses it for all cases of ectropion, excepting those extreme ones caused by cicatricial contraction, and also those accompanying or the sequel of neglected ophthalmia neonatorum.

The operation is easily performed without the aid of any special instruments, and simply with the use of cocaine. The external canthus and tissues beyond are thoroughly divided by a pair of strong scissors; the lower eyelid, which is usually the affected one, is then seized and its margin stretched sufficiently outward, parallel to the border of the other lid, so as to restore the palpebral aperture to its proper appearance; the portion of eyelid-margin thus made to extend beyond the site of the external canthus is removed, along with its contained eyelashes, by slicing it with a sharp knife. The upper and lower eyelids are then brought together, so that the original outer extremity of the one approximates exactly to the new extremity of the other eyelid. They are secured in this position by passing a silver-wire suture vertically downward through the substance of the upper lid, continuing it out through that of the lower one, and then twisting the ends firmly together. Two of these retaining stitches may be introduced close together, if necessary. The edges of divided skin, along with the deeper muscular tissues, including that part which recently formed the outer end of the affected eyelid, are simply stitched together with a continuous fine-silk suture.

No dressing other than a repeated dusting with dermatol need be used. It is well, however, to wash out the conjunctival sac regularly, which can be done with a lachrymal syringe, its point being gently inserted between the edges of the eyelids. The silk stitches may be removed in six days' time, the silver ones being left in for five or six days longer. So far as Dr. Scott has noticed, there is never any puckering apparent beyond the newly-formed canthus, and the small linear cicatrix is lost among the other lines often found there. In those cases where the condition of ectropion is extreme, and caused by cicatricial contraction of skin, etc., he has always found it necessary to resort to transplantation of skin from adjacent or distant parts, which, of course, is always somewhat tedious to do.—*British Medical Journal*, September 12, 1896.

Castration for Enlarged Prostate.—Dr. A. T. Cabot, of Boston, in an exhaustive paper on this subject, reaches the following conclusions:—

1. In the matter of mortality the operation of prostatectomy has a slight advantage over castration. It seems probable that, with later statistics reflecting the last improvements in the technique of prostatectomy, this advantage would be further increased.

2. Prostatectomy has the further advantage that it allows of a thorough examination of the bladder and of the discovery and correction of other conditions not before suspected. Stones are frequently removed in this way without adding to the gravity of the operation. In several reported cases of castration the absence of improvement has led to the subsequent discovery of stones which have required other operations for their removal.

3. Prostatectomy has, on the other hand, the disadvantages that it confines the patient for a longer time and that it is sometimes followed by a fistula. This occurred in one of the forty-two cases used in this paper.

4. It is too early to know whether any permanent loss of vigor follows castration when done on old men. The nervous effects which sometimes immediately follow the operation suggest a suspicion that with the testes the system may lose some tonic effect exerted by those organs.

5. The functional results of the two operations seem, at present, to be as nearly equal as possible, and the tendency to relapse shows itself in about the same proportion of cases after either operation.

6. The reduction in the size of the prostate after castration is largely due to a diminution of congestion. Later a degeneration and absorption of considerable portions of the gland may occur. The glandular elements are particularly affected by this atrophy.

7. Castration would seem to be especially efficacious in cases of large and tense prostates, when the obstruction is due to pressure of the lateral lobes upon the urethra.

8. Castration is of but little use in myomatous and fibrous prostates.

9. Prostatectomy has its especial field in the treatment of obstructive projections which act in a valvular way to close the urethra. There is, however, no form of prostatic obstruction which a skillful operator may not correct by prostatectomy.

10. Prostatectomy is, then, applicable to more cases than castration, and is especially to be selected when an inflamed condition of the bladder makes drainage desirable.—*Annals of Surgery*, September, 1896.

Therapeutic Action of the Extract of the Suprarenal Capsule in Certain Forms of Conjunctivitis.—According to DR. LUCIEN HOWE, of Buffalo, it is well known that a 2- to 4-per-cent. solution of the extract of the suprarenal capsule has a well-marked effect in contracting the blood-vessels of the conjunctiva. Attention has been called to this by a number of observers, and we owe to Dr. Bates, of New York, the credit of carefully formulating our knowledge of this subject in an excellent article in the *New York Medical Journal* of May 16, 1896. A sufficient number of observations have now been made to show without much doubt that a new and important agent has been placed in the hands of ophthalmologists and others treating diseases of the mucous membrane. There is no question but that a 2-per-cent· solution will cause a certain amount of contraction of the blood-vessels in an eye not inflamed, and that a 3-, 4-, or 5-per-cent. solution will produce a decided blanching of the ocular and palpebral conjunctiva within a couple of minutes after the application is made, even though the engorgement of the vessels be considerable. The contraction of the blood vessels does not last long, however, and as they begin to dilate they return gradually to the condition existing before the application was made. Dr. Bates considers that this is the only action of the preparation, that, in general, it has no special therapeutic effect, but it is of advantage to apply this a few times to an inflamed conjunctiva before using cocaine, in order that the latter may have its characteristic effect, usually absent when the anæsthetic is applied to an inflamed mucous surface.

In order to test the value of these statements the extract of the suprarenal capsule has been used in solutions of from 2 to 5 per cent. upon a number of cases at the Buffalo Eye and Ear Infirmary, and from the results Dr. Howe has noted its apparent usefulness in certain forms of conjunctivitis of the scrofulous type. While a limited experience shows that it is not of value in cases where the circulation in the deeper ciliary arteries is involved, it is apparently of decided benefit in cases in which the lymphatics play an important part. One patient, with well-marked scrofulous conjunctivitis, had, for several weeks, persisted in the ordinary routine usually employed for these cases without benefit; a 5-per-cent. solution of the extract was used every two hours and within forty-eight hours the conjunctivitis had almost entirely disappeared, together with the photophobia, which before was an annoying symptom. These cases seem to warrant the supposition that repeated contraction of the vessels has in some way a curative effect.

It is but fair to call attention to the disagreeable nature of the preparation, on account of the tendency of the solution to undergo putrefaction. It is to be hoped that a means will be obtained for obviating this inconvenience without impairing the efficiency of the drug.—*Moody's Magazine of Medicine*, August, 1896.

The Influence of Marriage and Pregnancy on Heart Disease.—PROFESSOR JACCOUD, of Paris, in discussing the case of a patient suffering from a mitral affection with tricuspid insufficiency, and presenting an attack of asystole after a fifth labor, though she had previously had two normal labors at term, considers the influence of marriage and pregnancy on diseases of the heart. Peter, having in mind the pulmonary accident to which pregnancy exposes such patients, believed that marriage or maternity should be forbidden them. This opinion is, perhaps, too absolute, and it may be admitted that, up to a certain point, the diseased heart may tolerate pregnancy, though it cannot be denied that the gravid state may give rise to serious troubles and, when repeated, may precipitate the appearance of asystolic symptoms. The physician, called upon to decide as to the advisability of marriage in such cases, should take into account a number of circumstances. First, he should consider the ideas and wishes of the interested person herself, bearing in mind the injurious effects which may result from opposition to a marriage which she desires. He should ascertain the degree of the heart affection, and whether it has already given rise to cardio-vascular symptoms, hæmoptysis, or marked dyspnœa. In such event he should advise against the marriage, though not too arbitrarily, if the trouble has yielded to medication in the past and if the new situation of the patient will be such as not to expose her to fresh attacks or will permit her to enjoy repose as soon as attacks occur. If all the conditions are favorable the physician may consent to the marriage, indicating the precautions necessary for the patient and the necessity of avoiding effort or fatigue in case she should become pregnant. Dr. Jaccoud attaches great importance to a mixed milk diet, two quarts (litres) of milk being taken daily. This plan, followed from the second or third month of pregnancy, is a powerful aid to the circulation on account of its diuretic action. He would also authorize marriage in the absence of any previous grave cardio-vascular symptom, provided the patient promises to follow this milk diet as soon as pregnancy occurs.—*Semaine Médicale*, September 5, 1896.

Etiology of Hard Fibroids of the Abdominal Wall.—Numerous theories have been advanced to explain the origin of these growths, which are usually met with in women from 20 to 35 years of age who have borne children. They are rarely seen in men, and seldom, if ever, in children. KRAMER, however, operated on a congenital sarcoma of the abdominal wall in a girl 4½ years old. The midwife had noted, soon after birth, a swelling as large as a hazel-nut in the right epigastric region. It remained stationary for about two years, and after that began to increase in size until it became as large as an orange. An incision of twenty centimetres showed that the tumor originated in the transverse fascia, and resection of the peritoneum was necessary in order to remove it. The sheath of the right anterior muscle of the abdomen was incised, and the muscle isolated as far as was necessary in order to bring it out from the fibrous envelope and fix it in the wound to fill up the loss of substance from the muscular layer and cover the exposed peritoneum. The wound was closed by sutures, and three weeks afterward the patient was able to get up. Nine months later there was neither recurrence nor ventral hernia. Kramer believes the tumor to have been a primary fibroid transformed into a sarcoma, the case corroborating the views of Grazer as to the congenital origin of these tumors. Traumatism and, especially, the distension of the abdominal wall incident to pregnancy cause their ulterior development.—*Arch. f. klin. Chir.*, B. lii, H. 1, 1896.

Scarlatinal Orchitis.—Faugère publishes a case of this kind, of which but few are recorded in literature. In the previously noted cases the orchitis was secondary to the disease, which developed normally and only reached the genital apparatus later on. In Faugère's case, however, the testicle was the first point affected, the scarlatina afterward becoming generalized. The patient, an adult, first complained of a sharp pain in the testicle, with swelling to such an extent that orchitis with vaginalitis was diagnosed, though the cause was not determined. At the end of two days the fever increased, the temperature went beyond 40° C. (104° F.), and at this moment only did the scarlatinal eruption make its appearance. The orchitis then rapidly disappeared, but returned in eight days, at the period of desquamation, definitely disappearing only eighteen days afterward. The author explains this abnormal evolution by supposing that the prolonged standing, incident to the man's duties as a postman, favored the primary invasion of the testicle by the scarlatinal virus.—*Jour. de méd. et de chir. prat.*, September 10, 1896.

Heredity of Cancer.—Manichon publishes the results of some observations on 23 families whose history was followed by him, and in which 69 cases of cancer occurred. Of these, 57 were of the stomach, 4 of the uterus, 3 of the breast, 3 of the rectum, 1 of the bladder, and 1 of the liver. Of the 57 cases of cancer of the stomach, 41 occurred in men and 16 in women. In 11 families the heredity manifested itself exclusively in the men and in 5 exclusively in the women. In 6 families it was shown sometimes in the men, sometimes in the women. It was also noted that 14 families out of 22 presented only cancer of the stomach, which in 8 families occurred only in the men. It seems from this experience that the hereditary nature of cancer cannot be doubted. It would also appear that consanguineous marriages, which are quite frequent in the region of France in which these families lived, played an important rôle in the heredity of the affection.—*Ibid.*

A Rare Case of Œsophageal Stricture.—Berger observed a case of stricture of the œsophagus in which the diagnosis was doubtful. As the progress of the affection had been slow, there was reason to doubt the existence of a carcinoma, and it was decided to try the effect of iodide of potassium, although the patient denied any history of syphilis. After one month's treatment with the remedy a sound of ten millimetres could be passed without difficulty and the weight of the patient had increased some thirty-five pounds. It is scarcely admissible that iodide of potassium would produce such results in a case of carcinoma or non-specific ulcer, and the author concludes, from this experience, that one should never fail, under similar circumstances, to try an antisyphilitic treatment, no matter what may be the symptoms.—*Deut. med. Woch.*, August 6, 1896.

Recent Suggestions in Therapeutics.

Acid Dyspepsia.—For a patient suffering from acid dyspepsia in which the hyperacidity was shown by analysis to be due to excessive secretion of hydrochloric acid Dr. Stewart prescribed the following: ℞ Normal liquid of *cannabis Indica*, 24 minims (1.5 grammes); dilute *hydrocyanic acid*, 40 minims (2.6 grammes); *bismuth subnitrate*, 2½ drachms (10 grammes); spirit of *chloroform*, 2½ fluidrachms (10 grammes); compound tincture of *cardamom*, 2½ fluidrachms (10 grammes); *water*, sufficient to make 4 fluidounces (125 grammes). M. Sig.: Two teaspoonfuls thrice daily. The more prominent symptoms of this affection are acid eructations and vomiting, both of which may be present when the stomach is entirely empty. Gastric distress, or gnawing sensations about the epigastrium, and headache are often present. The gastric digestion of starches may be in abeyance and the intestinal digestion imperfect as a result of the abnormally-acid chyme. In prescribing cannabis Indica it is very important to secure an active specimen. The value of the sample can be determined by adding the drug to dilute alcohol (1 part alcohol and 2 parts water). If the drug be active a green color is produced. (*Philadelphia Polyclinic*, September 5, 1896.)

Burns.—D'Arcy Power, of Chelsea, has tried picric acid for the treatment of burns in his hospital practice and is thoroughly satisfied with his results. The solution of picric acid is made by dissolving 1½ drachms (6 grammes) of *picric acid* in 3 ounces (90 grammes) of *alcohol*, which is then diluted with 2 pints (1000 grammes) of *distilled water*. This is a saturated solution of picric acid. The clothing over the injured part should be gently removed, and the burnt or scalded portion should be cleaned as thoroughly as possible with a piece of absorbent cotton-wool soaked in the lotion. Blisters should be pricked and the serum allowed to escape, care being taken not to destroy the epithelial surfaces. Strips of sterilized gauze are then soaked in the solution of picric acid, and are so applied as to cover the whole of the injured surface. A thin layer of absorbent cotton-wool is put over the gauze, and

Burns (*continued*).

the dressing is kept in place by a light linen bandage. The moist dressing soon dries, and it may be left in place three or four days. It must then be changed, the gauze being thoroughly well moistened with the picric-acid solution, for it adheres very closely to the skin. The second dressing is applied in exactly the same manner as the first and it may be left on for a week. (*British Medical Journal*, September 12, 1896.)

Enuresis.—DR. H. B. CARPENTER has been using the fluid extract of *rhus aromatica* with good result in incontinence of urine in children, giving from 2 to 15 drops three times a day. If the urine is acid and high-colored, it is well to begin the treatment by giving an alkaline mixture, as follows: ℞ *Potassium citrate*, 2 drachms (8 grammes); *spirit of nitrous ether*, 4 fluidrachms (16 grammes); *simp. syr.*, 1 fluidounce (31 grammes); *water*, sufficient to make 3 fluidounces (93 grammes). M. Sig.: A teaspoonful in water every two to three hours. In nearly all cases it is wise to add tonics, especially strychnine, to the treatment. (*Philadelphia Polyclinic*, September 5, 1896.)

Eucaine.—GÖRL used a solution of *eucaine* to anæsthetize the vesical mucous membrane in a patient with a tumor of the bladder, and found that the introduction of the liquid caused slight smarting and also rather abundant hæmaturia. This confirms previous observations to the effect that eucaine, unlike cocaine, produces hyperæmia at the seat of application. It must, therefore, be used cautiously when there is reason to fear hæmorrhage. As regards the local anæsthetic effect, Görl confirms, from an experience of several cases, the statements of other observers who have been satisfied with its power of dulling or abolishing sensation. (*Therap. Monats.*, July, 1896.)

Ichthyol in Ophthalmology.—M. de BOURGON, in his *Nouvelles formules d'oculistique*, gives the following prescriptions for the use of ichthyol: ℞ *Ichthyol*, 6 grammes ($1\frac{1}{2}$ drachms); *lanolin*, 10 grammes ($2\frac{1}{2}$ drachms); *benzoinated lard*, 20 grammes (5 drachms); *distilled water*, 24 grammes ($6\frac{1}{4}$ drachms). A topical remedy in burns, acne, eczema, and lupus. ℞ *Ichthyol*, 0.50 gramme ($7\frac{3}{4}$ grains); *oxide-of-zinc ointment*, 10 grammes ($2\frac{1}{2}$ drachms). To be applied to the edges of the closed lids in squamous blepharitis. ℞ *Ichthyol*, 0.20 to 0.50 gramme (3 to $7\frac{3}{4}$ grains); *starch-powder*, *oxide of zinc*, each 10 grammes ($2\frac{1}{2}$ drachms); *vaselin*, 25 grammes ($6\frac{1}{2}$ drachms). Mix carefully. To be applied to the palpebral conjunctiva with a small brush, in chronic conjunctivitis of eczematous subjects. If the ointment is well made, the burning sensation produced is very slight and of short duration.

Laryngeal Phthisis.—HEDDERICH made a trial of *paramonochlorphenol* in the treatment of 30 cases of laryngeal phthisis in the clinic of Professor Jurasz at Heidelberg. All the patients soon—usually after the second application—were relieved of pain; the breathing became easier, the ulcers cleaner and healed, and infiltration diminished. In severe, progressive cases no improvement was perceptible. In only 2 cases did the improvement amount to cure, and even as to these reserve is necessary, as they were lost sight of. As regards unpleasant effects, in 3 of the cases vomiting followed the applications and the patients felt weak and ill for the whole afternoon after it. Paramonochlorphenol is phenol in which one H is replaced by Cl; it acts like carbolic acid. It dissolves with difficulty in water, but easily in glycerin. For the larynx the author used a 10-per-cent. solution in glycerin, which he applied with a sound wrapped up in cotton-wool. A 20-per-cent. solution produces a white eschar, as liquefied carbolic acid does. This solution he used for the nose and pharynx. The author admits that the results of the treatment in his hands were not brilliant, though he adds that treatment in an out-patient department is subject to many disturbing influences. (*Münch. med. Woch.*, August 11, 1896.)

Night-Sweats of Phthisis.—Barth, physician to the hospital Broussais, administers the following: ℞ *Sodium tellurate*, 0.10 or 0.20 gramme (1¾ to 3 grains); *alcohol* at 90°, 50 grammes (1½ ounces). A teaspoonful in sweetened water morning and evening. Three days are usually sufficient to produce a suppression of the sweating. (*Gaz. hebd. de méd. et de chir.*, August 16, 1896.)

Ringworm.—Dr. Alfred Salter treated 40 cases of ringworm of the scalp at Guy's Hospital by means of *formic aldehyde*. The fluid was vigorously rubbed in with a largish brush or mop for ten minutes, the hair having been shaved round the margin of the patches. The application was repeated every other day on four occasions and then entirely discontinued. In some patients the head was painted every day for four successive days. Of the 40 cases only 4 required repainting from non-eradication of the disease, and in these the fault lay not with the remedy, but in the fact that, owing to the struggles of the child, no proper application could be made. The ages of the children treated ranged from 4 to 12, and the extent of the disease varied from a small, strictly-localized patch to areas which were practically co-extensive with the whole scalp. Microscopical examination was always made before commencing the treatment, and the actual presence of the trichophyton verified, while, before pronouncing any case cured, microscopical examination was again made. In 38 of the cases the fungus presented the characters of the trichophyton microsporon. Formalin thus applied induces discomfort and irritation of very brief duration rather than actual pain, and does not vesicate the scalp as it does the skin elsewhere. Only 3 cases showed any suppuration after its use, and in these the process was slight and did not destroy any of the follicles. It produces, however, a thick crust, just as weaker solutions cause desquamation upon the skin of the arm, and the subsequent application of some emollient is advisable to accelerate the removal of this exudation. Growth of healthy hair commences immediately, and in three or four weeks the denuded patch is covered

Ringworm (*continued*).

with hairs one-sixth inch long. In 6 cases œdema of the face was noted some hours after painting. In 1 boy this was so extensive as to completely prevent vision from swelling of the eyelids, and the forehead pitted one-half inch on pressure. The skin, however, was neither hot nor red, and there was no pain nor constitutional disturbance. The œdema only occurred when the area treated was very large, and the condition is probably analogous to that produced by a nettle-sting on a large scale. It is interesting in this connection to remember that the active toxic agent in the nettle is formic acid, and that it is thus closely related to the substance under discussion. The occurrence of this œdema renders it advisable either to deal with limited areas at a time or to warn the parents of the possible result if the whole scalp is to be attempted at once. (*British Medical Journal*, September 12, 1896.)

Dr. H. B. Sheffield, of New York, treated an epidemic of chronic ringworm of the scalp occurring at the Hebrew Sheltering Guardian Society Orphan Asylum by means of the following combination, curing some 370 cases in about four weeks: ℞ *Acidi carbol.*, *olei petrolei crudi*, āā 2 ounces (62 grammes); *tr. iodini*, *olei ricini*, āā 3½ ounces (108 grammes); *olei rusci* (German), q. s. ad 1 pint (500 grammes). M. Sig.: Apply over entire scalp once a day for four successive days; wash off thoroughly with green soap on the sixth day; then clip the hair close to the scalp and wash again as before. Repeat this course of treatment regularly for three successive weeks. After four weeks careful microscopical examination of the greater number of the cases no longer revealed the presence of the trichophyton fungus. To relieve the slight eczematous eruption which was still present he ordered the application, once a day, of the following mixture: ℞ *Resorcini*, *acidi salicylici*, āā 4 drachms (16 grammes); *alcoholis*, 4 fluidounces (125 grammes); *olei ricini*, q. s. ad 1 pint (500 grammes). This was well rubbed into the scalp. After about two weeks the hair began to grow upon the bald spots, and no relapse of the disease followed. (*American Medico-Surgical Bulletin*, September 5, 1896.)

☞ *Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."*

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(End of Editorial Department of Journal for October, 1896.)

FERRATIN.

Marfori (*Archiv. ital. de Biol.*, tome xxiii, fasc. 1, 2) publishes the results of some recent experiments upon the absorption of Ferratin and its physiological action. He states that the quantity of Ferratin that can be absorbed depends largely upon the condition of the mucous membrane of the gastro-intestinal tract. Sulphuretted hydrogen, which accompanies putrefactive processes in the intestine, slowly decomposes Ferratin (it immediately precipitates ordinary iron compounds.—Ed.), and so reduces the amount capable of being absorbed. The large amount (13.7 to 41.68 per cent.) that occurs after administration of saline purgatives Marfori ascribes in part to the aseptic condition of the bowel and in part to the fact that the saline purgatives cause a desquamation of the upper layers of the intestinal epithelium, and therefore expose a thinner layer of young cells through which absorption more readily takes place.

When the gastro-intestinal canal is in its normal condition the absorption of Ferratin is much less, according to Schmiedeberg; but since the latter's experiments render it impossible to distinguish between the iron of the Ferratin and the iron introduced in the food, Marfori proceeded as follows: He administered to the animal a saline purgative and fed it solely on milk; the lower part of the intestine was also cleared of saline enemata. About a week later Ferratin was given in repeated doses. The amount absorbed varied between 11 and 30 per cent. of the amount administered.

With reference to the question whether ill effects might not arise from long-continued administration of the drug, Marfori found that it was impossible to poison animals by injecting large doses into the blood; nevertheless, a man would need to take about two and a quarter pounds of Ferratin in the course of a month to produce a similar result, assuming as a basis for calculation experiments on dogs. Since he would actually, however, only receive about one-twentieth of that amount, there is no danger in continued administration of the drug,—a statement confirmed by clinical experiments.—*Univ. Med. Magazine*, November, 1895.

ANALGESIC AND SEDATIVE EFFECTS OF LACTOPHENIN.

Dr. H. D. Peterson, in a "Clinical Report on Lactophenin," in the *Chicago Medical Recorder* for August, 1896, says: "Among the newer remedies of this class (analgesics and antipyretics) is Lactophenin, one which so far seems to offer the best results with the least ill effects. Clinical tests have shown it to be of especial value in relieving pain and reducing temperature gradually and maintaining it at a lowered degree without frequent repetition. It is not disagreeable to the taste and is easily administered. The dose is 5 to 10 grains, and 45 grains may be given in a day. In doses of 15 grains it acts as a gentle hypnotic."

The author then reports a number of cases, from which we epitomize:

M. F., aged 37, laborer; suffered for years from periodical attacks of articular rheumatism, often preventing him from working. Lactophenin, in 8-grain doses four times daily, completely relieved him from pain; other remedies, especially salicylates, had failed.

Mr. W., aged 40, business man; long troubled with insomnia and frontal headache; extremely nervous from want of sleep. A 10-grain powder of Lactophenin at bed-time dispelled headache and sleep followed; no unpleasant symptoms in the morning.

Mr. S., aged 27; periodical attacks of migraine. One 8-grain powder of Lactophenin entirely relieved.

Mrs. D., aged 20, housewife; severe headache accompanying typhoid fever. Headache disappeared and did not return after 8-grain dose of Lactophenin; no noticeable effect on temperature.

Mrs. B., aged 25; facial paralysis on right side and neuralgic pains on left side. An 8-grain dose of Lactophenin relieved the pain and produced sleep.

Dr. Peterson concludes that, "where speedy relief from pain is desired, Lactophenin offers as good results as any remedy at our command."

GUAIACOL CARBONATE.

Dr. F. M. Greene, of Lexington, Ky., in an article on "The Treatment of Typhoid Fever," published in *The Journal of the American Medical Association* for August 8, 1896, states that the most important remedy of all is Carbonate of Guaiacol, which has been proved to be insoluble in the stomach. It acts by the destruction of the bacteria and consequent prevention of that rapid metabolism which, if not the cause, is always associated with the pyrexia of the disease.

Writing of "Some Therapeutic Uses of Guaiacol," in *The Therapeutic Gazette* for June 15, 1896, Dr. Horace G. McCormick, physician to the Williamsport Hospital, Pennsylvania, says as follows: "The smell of guaiacol was noticed in the stools of nearly all of these patients. It had been my practice to give the pure liquid guaiacol in emulsion. This is a rather disagreeable dose, and some objected so seriously to its use that I was forced to give it in capsules; when this was not expedient, I gave the Carbonate of Guaiacol dry upon the tongue in 2½-grain doses. I have never found this to disagree with the stomach, and patients do not offer any objection to taking it." Dr. McCormick concludes that, given internally, it is one of the best, if not the best, intestinal antiseptics known. By its use in typhoid fever the dry tongue and tympanites are abolished, rendering digestion and assimilation more perfect and reducing the probabilities of hæmorrhage to almost *nil.*

AUTUMNAL FEVERS.

Autumnal fevers now prevail. The liberal use of Platt's Chlorides for disinfecting discharges, deodorizing and refreshing the sick-room, is recommended by the most eminent physicians.

For disinfecting dejecta, dilute with 4 parts water. For sprinkling floors and moistening towels or cloths, dilute with 10 parts water.

THE HYPNOTIC EFFECT OF PELLOTINE.

Prof. F. Jolly reports his clinical tests with Pellotine muriate (the new hypnotic introduced by Dr. Heffter, of the Pharmacological Institute of Leipzig, and manufactured by C. F. Boehringer & Soehne, of Mannheim) in the *Therapeutische Monatshefte* for June, 1896. He employed Pellotine muriate, preferring this salt on account of its ready solubility in water; his experience covers 40 cases at the Charité Hospital of Berlin. In one-half of these cases the drug was administered during the day, either by mouth or subcutaneously; doses of $\frac{1}{3}$ grain (0.02) caused languor and sleepiness in quiet patients, but usually this effect followed only after $\frac{3}{5}$- to $\frac{9}{10}$-grain doses, causing several hours' sleep within one-half to one hour after administration. In some cases the pulse-rate was decreased, in others not at all, and only at the beginning of sleep. In painful affections (lancinating pains in tabes, neuritis, and ischias) sleep was also induced, but an anæsthetic effect was only occasionally noted before and after sleep. In excitable and delirious patients the above-mentioned doses were insufficient; even 2-grain (0.12) doses did not produce sleep, but had a calming effect—lasting all day—on the patient.

In 20 cases the drug was administered at night as hypnotic, and $\frac{3}{4}$- to $1\frac{1}{5}$-grain (0.05 to 0.08) doses were found to equal in effect 15 grains of trional or 22 to 30 grains of chloral. Of side-effects, excepting the inconsiderable slowing of pulse-rate, a few patients exhibited giddiness and a feeling of unrest before sleep ensued; a few also complained of similar feeling upon awakening in the morning. In several cases the hypnotic effect was not produced, but in these other hypnotics had also proved ineffectual. In no instance were serious side-effects noted.

The author then quotes 6 typical cases from his records in which four, one, and five hours' sleep were induced in 3 cases; 1 slept through the night for three consecutive nights; 1 slept peacefully through the night, while otherwise her rest had been frequently broken; and 1 slept fairly well, although there occurred two periods of wakefulness.

Prof. Jolly's report is generally favorable, and he concludes that he will continue the use of this new agent and will render additional report after more extended trials.—*American Therapist*, August, 1896.

TREATMENT OF TYPHOID FEVER.

Dr. Julia W. Carpenter, of Cincinnati, O., in a paper on "The Correct Treatment of Typhoid Fever," published in *The Woman's Medical Journal* for June, 1896, discusses the so-called Woodbridge treatment of that disease. She used the treatment in a typical case, with the result that in three weeks from the day that the treatment was begun, the patient rode to his office and resumed his work, greatly to the surprise of his friends, who all told him that he looked much better than when he was last at his office. She ascribes her success in this and in other cases entirely to the Guaiacol Carbonate that was used, since all the other ingredients had been used before without any specially beneficial effects.

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Selections from Society Proceedings.

FRANCE.

Société de Chirurgie.

Treatment of Stricture of the Rectum.—Berger referred to the communication made by Réclus upon this subject at the previous meeting, and expressed the opinion that progressive dilatation brings about very satisfactory results, provided certain rules are observed. The dilatation should be made slowly and carefully, and there should always be an interval of from twenty-four to forty-eight hours between the sittings. The insertion of a larger dilator should not be attempted at each *séance*, and it should be borne in mind that the axis of the pathologically-modified rectum is not the same as that of the normal rectum. Simple dilatation is not sufficient to cause the disappearance of the symptoms of stenosis; the rectitis must also be combated. The latter feature of the disorder is best treated by lavage. Dilatation does not always succeed; the conditions which cause its failure may, however, be previously determined and regarded as counter-indicative of this mode of treatment. Berger considers that dilatation is contra-indicated when (1) the stricture is located very high up; (2) when there is great abundance of suppuration, intensity of pain, and tenesmus; (3) when great weakness has induced a precarious condition of the patient; (4) when violent reaction, sometimes occurring after a sitting during which dilatation has been performed,—*i.e.*, chills with collapse, symptoms denoting an infectious condition,—is present. For the cases in which dilatation is not available Berger prefers linear rectotomy to extirpation.

Quénu cited an example which clearly demonstrated that specific treatment is of no use in stricture of syphilitic origin. In the case in question Quénu witnessed the formation of a syphilitic ulcer of the anus followed by stricture of the rectum. Very energetic antisyphilitic treatment failed, and it was necessary to resort to excision of the stricture. Notwithstanding this measure, the rectitis remained so intense that it was decided to make an artificial anus. Generally speaking, Quénu believes that none of the treatments result in a cure, but merely produce amelioration. He considers that the extent of the stricture should serve as a guide in indicating extirpation.

Schwartz cited a case in which posterior rectotomy, followed by dilatation, produced an excellent result, which was maintained during twelve years.

Réclus stated that in reporting his two cases he wished to call attention to the facility with which dilatation can be practiced when the mucous membrane is previously anæsthetized by the aid of a tampon saturated with a cocaine solution. He was able to proceed more rapidly. It is not necessary to leave an interval between the *séances* when this local anæsthetic is employed.

Association française d'Urologie.

Local Anæsthesia by Eucaine.—Legueu stated that since several months he has substituted eucaine for cocaine in operations requiring merely a local anæsthesia, particularly in those involving the urinary apparatus. Possessing equal, if not superior, anæsthetic properties, eucaine has the advantage of diminished toxicity; the salt being also more stable, the solutions may be sterilized by boiling. While 0.06 gramme ($\frac{9}{10}$ grain) of cocaine is sufficient to kill a guinea-pig in three-fourths of an hour, Legueu found, in comparative experiments made by himself and his pupil, Lihon, that 0.08 gramme ($1\frac{1}{4}$ grains) of eucaine only caused the death of a guinea-pig of equal weight in one hour and a half.

He uses a 1-per cent. solution. The doses injected into the urethra or under the skin never exceed 0.05 or 0.06 gramme ($\frac{3}{4}$ or $\frac{9}{10}$ grain). With regard to the technique of the procedure, he follows exactly the rules given by Réclus for cocaine; he has never observed any of the accidents attending the primary use of cocaine. In cystoscopy he uses a 5-per-cent. solution, of which he injects from 160 to 200 grammes ($5\frac{1}{3}$ to $6\frac{2}{3}$ ounces) into the bladder. Contrary to cocaine, eucaine possesses congestive properties, which would counter-indicate its use in cases in which there is pronounced bleeding.

Carlier called attention to the fact that the sterilization of solutions of cocaine is not as difficult as it has been stated. Thanks to the following procedure, suppuration never occurs: Packages containing 0.05 gramme ($\frac{3}{4}$ grain) of cocaine are prepared with sterilized paper, and at the time of the operation the contents are poured into sterilized water. In this connection Carlier also mentioned a special method for the production of complete anæsthesia of the penis. This consists in making an injection at the base of the organ on a level with the dorsal nerve, and another in the lateral and inferior portions of the organ. Circumcision can thus be practiced; the frænum alone sometimes remains a little sensitive.

GREAT BRITAIN.

SIXTY-FOURTH ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION.

Discussion on Dysmenorrhœa.—MURDOCH CAMERON, of Glasgow, considered the spasmodic variety by far the most common; as there is frequently little to be detected beyond the symptom of severe spasmodic pain, it gives rise to much anxiety. As regards treatment of this form, some relief may be obtained by sedatives externally and internally, but there is always the danger of setting up an opium or chloral habit. It is, therefore, better to dilate the uterus, either by tents or solid instruments. The use of tents is not free from danger, both from sepsis and from the fracture or tearing away of a piece of the tent upon extraction. To effect rapid dilatation the solid dilator well graduated is to be chosen. The uterus can be easily secured by the vulsellum forceps if a sound is previously introduced into the cavity, and a series of dilators can then be passed rapidly, with the result that the patient is relieved, at least for many months.

CHRISTOPHER MARTIN, of Birmingham, stated that the causes of dysmenorrhœa may be either (*a*) extra-uterine or (*b*) intra-uterine. The treatment differs markedly in the two classes of cases, and what would relieve in the one would be worse than useless in the other. Three factors are concerned in the production of the pain of dysmenorrhœa: (*a*) contraction of the muscular fibres of the uterus or Fallopian tubes; (*b*) increased spasm or blood-pressure in the tissues of uterus or appendages,—congestion; (*c*) neuralgia of the uterus or the appendages. As to treatment, we must treat the cause. Nearly all cases are benefited by rest at the periods, hot vaginal douches during and between the periods, and, in inflammatory cases, tampons of glycerin and ichthyol, and saline aperients. Morphine and alcohol will give great relief, but must never be recommended. The administration of alcohol to young women at such times is to be blamed for much of the secret drinking that prevails in both the upper and lower classes. The drugs he had found most useful are bromides and belladonna, antipyrin, and cannabis Indica (in the form of suppositories), and both viburnum prunifolium and viburnum opulus are excellent ovarian and uterine sedatives. Operative measures should only be resorted to when other and less severe remedies have failed. In cases of dysmenorrhœa due to spasmodic contractions of the uterus or stenosis of the cervix (if there be no signs of extra-uterine disease), dilatation is often of some service, but is seldom of more than temporary benefit. The patient is relieved for three, six, or even twelve months, and then the old pain returns, and the dilatation has to be repeated time after time. In cases of dysmenorrhœa due to chronic pelvic peritonitis, binding down and matting together the uterus, ovaries, and tubes—cases in which the ovaries are cystic and the tubes perhaps occluded, and the uterus retroverted and adherent to the rectum—he had found very marked and permanent benefit result from a "conservative operation" on the appendages. He opens the abdomen, frees the uterus, ovaries, and tubes from the adhesions that bind them down, and after ignipuncture of the cystic or sclerosed ovaries fixes the fundus forward to the anterior abdominal wall. In grave and otherwise incurable lesions of the appendages, such as abscess of the ovary or pyosalpinx, the removal of the diseased organs is strongly indicated.

J. Inglis Parsons, of Chelsea, said that during ten years' experience at the Chelsea Hospital for Women he had never met with a case of membranous dysmenorrhœa nor seen one in the practice of his colleagues. It appeared to be a pathological curiosity. The spasmodic neuralgic form without any pathological lesion was also extremely rare. Unmarried women who were not anæmic should, if necessary, be examined under an anæsthetic, and the probability was that some lesion would be found to account for their dysmenorrhœa. A great number of cases occurred in anæmic young women, and full doses of iron would cure the anæmia, and with it the dysmenorrhœa. The worst cases were usually due to anteflexion, which undoubtedly caused obstruction, and in many of them the sound would not pass until the uterus was straightened. The patients themselves stated that after hours of agony (presumably from contractions of the uterus) they passed some clots, and were immediately relieved until their next period. Dilatation gave relief, but must be repeated. He also had much doubt about the ovarian origin of dysmenorrhœa, to which the formation and growth of an ovarian cyst did not give rise. He had at present a case of tender, enlarged, and prolapsed ovary without any menstrual trouble. No doubt when there was salpingitis, and the ovaries and tubes were matted together by perimetritic adhesions, abdominal section must be done and the diseased appendages removed. But there was not any scientific proof that the ovary *per se* ever caused dysmenorrhœa. When no lesion could be found the fault was in the nervous system, and to this the attention must be directed.

Fibromyoma not infrequently caused dysmenorrhœa, even in women under 30. The tumor might be very small and escape notice unless a careful examination was made under an anæsthetic. For these cases the negative pole of the constant current in mild doses every other day was of great benefit.

JOHN D. WILLIAMS, of Cardiff, called attention to one aspect only of the subject,—namely, that presented by the co-existence of painful menstruation and acute anteflexion of the uterus. The class of patients who suffered from this type of disease were usually, if married, sterile, and the supervention of pregnancy often effected a cure; the pain which they suffered was colicky in nature, was felt in the hypogastric region, and dated from puberty. Pelvic examination revealed the absence of any inflammatory lesion; the uterus bobbed up and down on the examining finger with great mobility, and was sometimes displaced backward, sometimes to one side. The passage of the sound was in some cases a painful process. The degree of anteflexion might be in excess of the normal, but still not be pathological, for, according to Schultze, who first described the condition, there was in that lesion an inflammatory shortening of the utero-sacral ligaments. The pain of dysmenorrhœa was probably due to irregular abnormal contractions, set up by a diseased condition of the mucous membrane at the seat of flexure. Since the researches of Vedeler and Herman it was no longer customary—and rightly so, in the speaker's opinion—to speak of obstructive or mechanical dysmenorrhœa, and one must search for some cause other than the angulation-blockage at the seat of flexion, operating either alone or in conjunction with the flexion, to account for the painfulness of the menstruation. As regards treatment, rest in bed and saline aperients had been of very little value indeed in his hands. Better results were obtained by the use of nitrite of soda combined with a diffusible stimulant; but for obvious reasons such a treatment could not be followed month after month. Dilatation was successful to some measure,—that is to say, the pain was kept away from three to six months, but returned later. Dilatation performed a second and third time yielded slightly better results, but never a complete cure. The author referred to a friend who had stated that in his experience very good results followed the performance of Dudley's operation, which consisted in incising and removing a wedge-shaped portion from the posterior lip in this type of cases. He would resort to this procedure at the next opportunity.

AMAND ROUTH, of London, drew attention to the extreme divergence of the views expressed, and thought we should look upon dysmenorrhœa as a symptom associated with many other constitutional or local symptoms, and then treat the whole group of symptoms, tracing all back to the main constitutional or local *origo mali*, of which the dysmenorrhœa was simply a solitary evidence. If there were a serious local disease by all means let it be treated by operation, if need be; but that was not treating the dysmenorrhœa, it was treating its cause. Anteflexion was not a cause; it was associated with cases of spasmodic dysmenorrhœa, but was not the cause. As the uterus matured, the type of uterus peculiar to these cases (anteflexion; conical cervix; pinhole, but patent, os) disappeared. In spasmodic dysmenorrhœa Routh first treated the constipation, the anæmia, or other constitutional state, and then, if need be, examined per rectum, and, if the perimetrium were involved or the ovary enlarged, their state was attended to. As a rule, antispasmodics were very beneficial. The best of these were phenacetin (10 grains) in cachets, two doses being usually sufficient; antipyrin or nitroglycerin ($\frac{1}{100}$ grain). Locally a glycerin and gelatin pessary was very useful. If these simple measures failed, then, and then only, should any local treatment be adopted, dilatation being often of great value.

John A. Lycett, of Wolverhamptom, thought that, although local conditions were common causes of dysmenorrhœa, the constitutional state to which one speaker only had referred was worth more attention than had hitherto been accorded it. In the absence of local cause it was important to investigate the past and family history of the patient. In the rheumatic diathesis he had found advantage from the administration of cimicifuga racemosa and other allied remedies. Struma was often an association, if not an etiological factor.

Bedford Fenwick, of Soho, said that very many cases of dysmenorrhœa were due to congestion caused by constipation or otherwise, and were improved by scarification and saline purgatives, especially sulphate of soda. Too great benefit had been attributed to dilatation, the effects of which on the cervical canal had completely passed away in an hour or two; but there was no doubt that constitutional taint and especially the rheumatic diathesis was an important element in a very large number of cases.

J. W. Byers, of Belfast, alluded to the importance of attending to the personal equation in patients with dysmenorrhœa. Each case had to be treated by itself, and that medical man would have the best results who endeavored to determine the cause of the symptoms in any individual case as well as the personal history of his patient, and who based his treatment accordingly. In some cases attention to such conditions as anæmia, the rheumatic element, or constipation would cure the ailment; in others dilatation, done with the strictest antiseptic precautions; while in many simple cases in unmarried women, attention to the nervous system, and an endeavor to make the patient less introspective, and by bicycling, or some occupation to direct her mind away from her painful pelvic sensations, would probably, as he had often observed, bring about a complete cure.

Munro Kerr, of Glasgow, replying to Bedford Fenwick's objections to dilatation, was prepared to admit that in time the cervical canal might return to the narrowed condition that existed before dilatation, but was satisfied that very distinct benefit resulted for some time, perhaps for a few months. It would be just as absurd to expect that the cervical canal would remain permanently dilated as to expect that permanent good would be derived from a single dilatation of a stricture of the urethra. The patient had to return again every few months and have the canal of the cervix dilated. It might be urged that the quantity of fibrous tissue in the cervix, and especially in those cases of small conical cervices which were the cases that seemed to derive the most benefit from dilatation, was very great indeed, consequently the treatment by dilatation must be conducted in the same manner as dilatation of a stricture of the urethra,—that is, by repeating the operation from time to time. But dilatation was not always, nor in the majority of cases, the best treatment. Byers had referred to the fact that the nervous system was frequently not in its normal condition. In these cases he (the speaker) had seen very considerable benefit from treatment by electricity, either by the continuous or faradic current. He mentioned this as none of the previous speakers had referred to this method of treatment.

John Connel, of Peebles, drew attention to the fact that in sterile married women prescription of abstinence from marital relations for a longer or shorter time, followed by free dilatation immediately before their resumption, would often prove successful in curing dysmenorrhœa, and had in his experience proved successful in at least three instances where sterility had existed for over three to five years. He mentioned a case in which troubles of the vermiform appendix had been treated by a distinguished gynæcologist as ovarian disease, and insisted on the absolute necessity of a thoroughly careful diagnosis in all cases of right-sided abdominal pain occurring in that region. He heartily agreed with Byers on the advantages of bicycling, and, if growing girls, especially when anæmic, were systematically encouraged to practice that exercise in moderation, we should by and by have less of spasmodic dysmenorrhœa.

C. E. Purslow, of Birmingham, said dysmenorrhœa was often met with in women in whom the first few years of menstrual life had been free from pain, and in whom, therefore, it could not be due to congenital conditions, but was probably of neurotic origin. He strongly deprecated local examinations or mechanical treatment unless good was likely to be done; it was a great misfortune for a young unmarried girl to get the idea that she had something "wrong with her womb," and he would rather advise that she should be encouraged as much as possible not to dwell on her symptoms.

Miss G. R. Cadell, of Edinburgh, thought that dysmenorrhœa seldom occurred at puberty except in cases of an infantile uterus, and was often due to some cold or overexertion, easily cured if taken in time, but, if neglected, extremely intractable. Neither alcohol, nor morphine, nor even the bromides should be prescribed. The mind ought, if possible, to be diverted from the uterine condition, and bicycling or any work or amusement that would take the patient out of herself would be useful.

Murdoch Cameron wished, before closing, to refer to the marked increase of dysmenorrhœa resulting, in his opinion, from the too common custom of using preventives against conception. Physicians should set themselves against such habits as injurious to the woman herself and to the whole body of society.—*British Medical Journal*, October 24, 1896.

UNITED STATES.

New York Academy of Medicine.

Congenital Stenosis of the Pulmonary Valves.—H. Koplik presented two cases illustrating the extremes, so far as the symptoms were concerned, of congenital stenosis of the pulmonary arteries. The first patient was an infant 8 months of age. The mother stated that the labor had been a severe one, forceps having been used. She did not see the babe until it was 9 weeks old, when she noticed that when it cried it became cyanotic. The skin then was grayish, and the extremities, even in the summer, were cool and below the normal temperature. Percussion showed nothing abnormal about the heart, but on auscultation Koplik could hear a distinct rasping murmur over the second intercostal space to the left of the sternum, conducted to the apex and also to the base of the heart. The ends of the fingers and toes were slightly bulbous. It was not what was called a blue baby, but it became cyanozed only at times.

The second case was that of a boy, aged 16 years, who up to the fourth year had been healthy. Then, after gastro-intestinal disturbance, he became cyanotic; the extremities were cool and remained so, even in summer. At the present time the boy was markedly blue, the conjunctivæ and lips showed cyanosis, the surface-temperature was below normal, the extremities of the fingers and toes were bulbous; on exertion he had attacks of great dyspnœa. There were frequent attacks of headache. In this case, in addition to the loud murmur over the second intercostal space to the left of the sternum, there was dilatation of the heart. It was not unlikely that there was, besides stenosis of the pulmonary valves, a patent foramen ovale.

Northrup stated that two cases of "blue baby" having appeared at the foundling asylum about two years ago, reference to J. Lewis Smith's work on "The Diseases of Children" showed that this author ascribed the disorder to a congenital narrowing of the pulmonary artery and defect of the septum ventriculorum. It was also stated that many such subjects, surviving the second year up to the twenty-fifth year, died of cerebral abscess. One of the patients seen by himself had had whooping-cough, and he had expected soon to confirm the anatomical diagnosis; but the patient survived, and also passed successfully through an attack of measles. The child was then expected to have reached a state of average health. One day, however, he was found blue, delirious, and stupid, and a diagnosis of cerebral abscess was made. Autopsy revealed congenital narrowing of the pulmonary artery, defective septum ventriculorum, and cerebral abscess. A similar result is to be expected in the second case, but the child is still living. One of the physicians connected with the Presbyterian Hospital who was interested in these cases on meeting a young man on the street whose face and hands were blue ventured to ask him some questions, and received the promise of a visit to the hospital, where he could be examined. He did not, however, come on the appointed day, but later was brought in delirious and with symptoms pointing to cerebral abscess. As in the cases already presented, and in his own, there was a purring thrill at the second costal cartilage on the left, pointing to the diagnosis already suspected to exist. Autopsy revealed narrowing of the pulmonary artery, defective septum ventriculorum, and cerebral abscess. Two similar cases had been reported at the recent meeting of the American Pediatric Society.

Arthritis Deformans.—W. L. Stowell presented a girl, 9 years of age, and photographs taken at different periods, illustrating arthritis deformans. There was no family history of rheumatism and in other respects it was also negative. The patient's trouble dated from an illness in the summer of 1893, when she had fever and chills for two weeks. She had then much lameness, and a month later the joints of the hands and wrists became involved, and within three months the elbows and knees were swollen. She was in a hospital three months, and in the fall of 1895 was sent to Randall's Island Hospital, at which time the head was immovable and nearly rested upon the sternum; the shoulder-joints were semi-ankylosed; the elbows semiflexed and enlarged; the wrists enlarged, tender, and almost motionless; the metacarpal and carpal joints stiff; the hips fixed; the knees much enlarged; the ankles thick, tender, and stiff, and the foot was partly extended. The muscles were atrophied. There was no evidence of visceral trouble. The condition had been stationary for nearly two years until some months since, when in addition to medicinal treatment the nurse began patiently and systematically to carry out massage and encourage voluntary movements, including attempts at walking. The improvement had been striking, but all the joints were still more or less enlarged and stiff and the muscles atrophied. The medicinal treatment had included, from time to time, iodide of potassium, wine of colchicum, codliver-oil, iron, hypophosphites, and strychnine, but the improvement was attributed, for the most part, to massage, motion, and hot baths.

In a brief review of the literature of arthritis deformans it was stated that J. G. Mitchell regarded it as neurotrophic entirely, and Osler agreed with him. There was no evidence that gout or rheumatism predisposed to it.

Progressive Muscular Atrophy.—Stowell presented a girl, aged 13 years, with progressive muscular atrophy, which began, it seemed, after an attack of diphtheria when she was 5 years of age. The family history was negative except that one uncle committed suicide during an attack of melancholia. About a month after she had had diphtheria the parents noticed that the patient's face began to get smooth, lose its folds and expression; later the eyes could not be closed tightly; she could not whistle; within a year she would stumble easily; the muscles of the arm wasted, but the forearm had remained well to the present time. All the muscles of the back and shoulders had wasted greatly. The gluteals were well developed. The author quoted Sachs to the effect that the several types of progressive muscular atrophy—the facial, the scapulo-humeral, and the pseudohypertrophic—were the same disease. Out of forty-nine autopsies thirty-four showed lesions of the spinal cord; so that the weight of evidence was in favor of its being due to a central lesion. The treatment had been tonic, including iron, strychnine, quinine, and arsenic, but the disease had progressed constantly.

Nammack presented a colored boy, about 9 years old, with commencing muscular atrophy or pseudomuscular hypertrophy. Three months ago the mother noticed that he was disinclined to stand, and about a week ago he began to stumble and fall easily. The shoulder-muscles showed greatest atrophy, but those of the back were also weak, permitting of marked antero-posterior curve of the spinal column. The thigh- and calf- muscles were large, presenting apparently pseudomuscular hypertrophy. The neck- and arm- muscles also showed wasting.

Frederick Peterson thought the colored boy had not pseudohypertrophic paralysis, although there were some of the symptoms of that disease. The gait was rather a spastic-paretic gait, the knee-jerks were much exaggerated, and there was ankle-clonus,—symptoms pointing to a lesion in the pyramidal tracts, probably somewhere in the cord. Furthermore, there had been some incontinence of urine and some rigidity of the neck-muscles. There was weakening and wasting of the muscles of the arm, without loss of power in any particular muscle. Everything pointed rather to a lesion in the cervical cord, yet in the short examination made he would not pronounce that a final diagnosis. Alluding to Northrup's case he stated that he had never before heard of the frequent connection of abscess of the brain with cyanosis. The pathological relation would make an interesting study. As a rule, the differentiation between atrophies and dystrophies was not difficult. The atrophies were generally called spinal; the dystrophies were primarily muscular. In the latter the muscular fibres, as a rule, underwent degeneration at an early period of life. The differentiation was made by about four symptoms: in the spinal form of progressive muscular atrophy there were atrophy and fibrillary tremor, no heredity, no hypertrophy, presence of reaction of degeneration. In dystrophy there was heredity, atrophy with hypertrophy, no fibrillary tremor, no reaction of degeneration. As long as any of the muscle remained it reacted in the normal manner. Dr. Peterson had never seen even partial reaction of degeneration in such cases.

Progressive Muscular Dystrophy.—NAMMACK also presented a man aged 26 years; family history negative except that his mother had died of phthisis. The patient remembered no illness, denied syphilis, but admitted free use of alcohol before the commencement of his present trouble. Eight years ago he began to have sensations in the back as of overtire. Seven months later the shoulders began to diminish, the muscles wasted, and three years later the muscles about the hip and thighs began to waste, and he lost power to walk. There was no muscular twitching and no sensory disturbance. The man's occupation threw some light on his disease, he having been a public contortionist. The disease had advanced so far as to render him almost helpless.

In the discussion E. D. FISHER stated that he regarded the case of the man presented by Nammack as a typical one of progressive muscular atrophy of hereditary type. Such cases commencing in youth, whether of the scapulohumeral or other form, were, as a rule, of hereditary taint, and were quite distinct in their course and in their pathology from the progressive muscular atrophy of spinal type. In the former no lesion was found in the spinal cord. He had shown this man to classes at the University Medical College the past two years, and regarded the case as typical, but had not been able to obtain a history of hereditary taint. The subject belonged to a family of acrobats, and it was not unlikely this career had had something to do with his disease. As long as the muscular atrophy was not complete, there was always some electrical reaction. In his experience there was rarely complete reaction of degeneration, but there might be partial reaction.

Arthritic Muscular Atrophy.—NAMMACK presented a patient, a boy of about 13 years, who was said to have had rheumatism three years ago, affecting the right elbow and shoulder. The atrophy seemed to have been limited chiefly to the supraspinatus and infraspinatus of the one side. It was an interesting fact that since the mother had begun to rub the region (with soap-liniment) in September the atrophy had largely disappeared.

Rachitic Muscular Atrophy.—H. D. Chapin, presented an infant, 15 months old, which had been well up to the sixth month; then it was noticed that the head seemed too heavy for the body. It became very irritable and at times would lie in a semicomatose condition. There was flattening of the occiput; the muscles of the body were very weak, but seemed not much atrophied. Dr. Chapin thought the case was one of rachitis,—a disease which manifested itself in various forms, in some instances the muscles being most affected.

Epistaxis and Cardiac Disease.—Dr. Koplik presented a girl of about 7 years who at about the age of 2 years began to have attacks resembling rheumatism, with fever and pain in the joints. These attacks recurred nearly every year. Later she began to have attacks of very persistent nasal hæmorrhage, recurring at intervals of a week, a month, or several months. The last hæmorrhage threatened life, and left her nearly exsanguinated, but finally ceased of its own accord. The child was still anæmic. Examination of the heart showed double mitral lesion and dilatation of the left ventricle, and possibly also of the right.

Early Enlargement of the Liver.—T. S. Southworth presented a boy of 5 years, with enlargement of the liver, which he attributed to fatty infiltration. There had been 4 other children in the same family, of whom 1 had died of tuberculous meningitis, 1 of gastro-intestinal fever, and 1 was feeble-minded. The patient presented had always had a large abdomen, and when a baby had diarrhœa; being in a condition of marasmus, it was given brandy. The abdomen continued to increase in size, which increase at the second year was attributed to sarcoma of the kidney; but this was proven not to exist. Before coming under Southworth's observation at the fourth year the boy had convulsive seizures, which had been pronounced epileptic. Under treatment directed more particularly to the gastro-intestinal tract, the convulsive seizures had ceased and the patient had improved; yet during the past summer he had had occasional attacks of fever, vomiting, pain in the abdomen, slight jaundice, sometimes diarrhœa. There was purulent otitis media. In connection with the etiology of the fatty liver mention was made of the use of starchy food, as well as of brandy, during infancy.

Cretinism.—Koplik presented two patients and reported progress on the treatment of cretinism. The patients were about 3 years of age, and had been under treatment over a year. When first seen the signs of cretinism were well-marked,—dwarfish appearance, protuberant abdomen, thick lips, thick tongue, flattened nose, œdematous eyelids, dull appearance. One patient had abscesses; rectal temperature, 96° F.; extremities blue; hæmoglobin, 25 per cent. Thyroid extract was administered. When the patient was last shown, a year ago, the percentage of hæmoglobin had risen from 25 to 45, and at present was 75. In the other case there had been a similar rise from 18 per cent. West thought that the original dose of thyroid could not be adhered to as the children grew older; they should be kept on just as large doses as they could stand. Although there had been marked improvement, he thought his patients would eventually become still brighter under larger doses of the thyroid.

J. P. West, of Ohio, presented by invitation photographs of the case of cretinism treated with great success with thyroid and reported by him in the *Archives of Pediatrics.*

W. P. Northrup had himself treated two cases by thyroid. He had been able to bring them up to a certain point of improvement, but they would return again to their former condition. He had thought a change of the proportion of thyroid might help, but the relapses continued to take place.

West said that after nine months' treatment he was able to increase the dose, given twice a day, to a grain and a half, and within a year the girl grew eight and one-fourth inches and gained fourteen pounds. At one time the thyroid was left off three months, and there was a relapse. He thought it advisable to increase the amount whenever relapse threatened.—*Medical Record*, October 17, 1896.

Sulphonal in the Treatment of the Night-sweats of Phthisis.—F. Combemale, of Lille, has found, after a series of clinical observations, made with the assistance of Descheemaeker, that sulphonal administered in doses of from 15 to 30 grains (1 to 2 grammes) is efficacious in combating the night-sweats of tuberculous patients, while exercising at the same time its usual hypnotic effect. This antihydrotic action, however, is only produced in the cases in which the preliminary lesions are not very far advanced, and fails in subjects having large cavities in the lungs. The medicine should be given just before retiring. If it is administered with the evening meal, as is frequently done when sulphonal is given as an hypnotic, the night-sweats are in no way benefited. This is probably due to the fact that the antisudorific action of the sulphonal is rapidly exhausted. The author found that patients become accustomed to sulphonal when it has been administered more than fifteen days. (*Journal d'Accouchements*, November 1, 1896.)

Selections from Reports of Members of the Annual's Staff of Correspondents.

Russia.

DR. J. DRZEWIECKI,

Редактор-Корреспондент из области русской литературы, касающейся: Общей медицины и терапіи, педіатріи, акушерства, гинекологіи, ларингологіи, отологіи, гигіены, демографіи, судебной медицины, гистологіи, бактеріологіи, анатоміи и физіологіи.

Всѣ періодическія, медицинскія изданія, сочиненія, стат'и, монографіи и т. д., изданныя на русском языкѣ и касающіяся вышепоименованных предметовъ должны быт' адресованы на имя

Дра Држевецкаго.

87 Краковское Предмѣст'е,
Варшава.

The Treatment of Tuberculosis by Serum.—Basing his opinions upon forty-eight personal experiments made upon animals, TURKIN comes to the following conclusions: 1. Horses are the most suitable animals for the reception of the antituberculous serum. 2. By the gradual introduction into the blood of a horse of bacilli of different degrees of virulence, a serum possessing a certain degree of antituberculous virtue can be obtained. 3. Upon any new introduction of cultures of the bacilli of tuberculosis into the organism of the horse the blood seems to assume greater therapeutic properties. 4. The injection of antituberculous serum obtained from the horse is painless, and in guinea pigs and cats it does not occasion any local reaction. 5. The favorable action of this serum is manifested in affected animals by a falling of the temperature after repeated injections. 6. Animals inoculated with the bacilli of tuberculosis, when treated with antituberculous horse-serum live longer than the control animals. 7. In animals infected by the bacilli of tuberculosis and treated by the horse-serum the development of tuberculosis is arrested to a certain degree, but they ultimately die of fatty degeneration of the parenchyma of the organs. 8. Thus the treatment of infected animals with the horse-serum only has the effect of retarding their death for a certain length of time. 9. By introducing tuberculin into the blood of the dog he succeeded in obtaining from the latter a serum with which he was able to arrest the course of tuberculosis in infected animals. 10. The serum from horses rendered unsusceptible to the tubercle bacillus had the same action in the treatment of infected cats as well as guinea-pigs. 11. In view of the changes occurring in animals during their treatment with the serum, the proposition of Maragliano to treat phthisical subjects with antituberculin seems to be premature.—*Vratch*, No. 30, 1896.

Friedlander's and Frankel's Bacilli.—FLEROFF has attempted to prove the pathogenic action of Friedländer's and Fränkel's microbes by bacteriological investigations and experiments upon animals, and concludes that neither the one nor the other can be considered as specific for croupous pneumonia, but that they belong to the class of microbes producing suppuration. In order to accept any microbe as pathogenic for a disease it is necessary that (1) it should be present in all cases of this disease, (2) it should not be in any other disease, and (3) being inoculated in an animal it should produce symptoms of the disease of which it is pathogenic. Neither Friedländer's nor Fränkel's microbe is found in all cases of croupous pneumonia, but both are often met with in many suppurative processes. When injected into the trachea of animals they occasioned not croupous, but catarrhal pneumonia. Besides Fränkel's diplococcus and Friedländer's bacterium, it is well known that the pyogenic streptococci and staphylococcus aureus are also present in croupous pneumonia. Thus it should be admitted that this type of disease is provoked by four microbes. The author, therefore, states that the etiology of croupous pneumonia has not been thoroughly determined, and requires further investigations in different directions. Consequently the presence of Fränkel's diplococcus in the sputum of the patient has no diagostic value, the more so as it may be found in the sputum and other secretions and excretions of healthy persons.—*Inaugural Dissertation*, Moscow, 1895.

Changes in the Testicles in Scarlet Fever, Diphtheria, Typhus Exanthematicus, and Croupous Pneumonia.—According to the experiments of BOYNOFF, one and the same change is present in all the above diseases; no special change proper to only one of them was observed. The changes gradually increase as the age of full genital activity is approached. The interstitial tissue is subjected to serous infiltration and the invasion of lymphoid corpuscles. The endothelium of vessels undergoes albuminous and partly fatty degeneration. Blood-vessels are dilated and full of blood. In some places small hæmorrhagiæ are found in the interstitial tissue, and sometimes the presence of very small heaps of yellow, granular pigment may be ascertained. The tunics of spermatic vessels are subjected to serous infiltration and swelling. In the cells of the spermatic vessels and their nuclei a turbid swelling (*Trübeschwellung*), serous and fatty degeneration, necrosis, and the formation of vacuolæ in the nuclei are observed. Lymphoid corpuscles are sometimes present in large quantities in the spermatic vessels and their walls. There is no formation of spermatozoa in the spermatic vessels, and those which were previously formed gradually disappear.—*Inaugural Dissertation*, St. Petersburg, 1896.

The Temperature-Tracings of Typhus.—KILDIUSHEVSKY has examined more than 10,000 charts of typhus patients in the Barrack Hospital of St. Petersburg, from 1882 to 1891, and reached the following conclusions: 1. Wunderlich's schema for the tracings of temperature should be given up as not corresponding, except with rare exceptions, to the real course of temperature in typhus. 2. This schema does not correspond with the actual course, especially in the first two stages, those of invasion and depression: the temperature-tracing generally rises more rapidly than is stated by Wunderlich; there is, in the majority of cases, no arrest of temperature at any one point. 3. In the majority of cases the course of temperature is usually as follows: Comparatively rapid increase, reaching its maximum on the second or third day. Just as the temperature has reached its highest a tendency to falling may be observed. 4. In consequence of this the general appearance of the curved line of temperature for typhus is that of a double incline plane, and this form must be regarded as the most important characteristic. 5. Although the form of double incline plane is characteristic, it cannot be considered as belonging absolutely to the curve of abdominal typhus. 6. As in typhus, this curve also shows itself in 70 to 75 per cent. of all cases, and in other diseases—according to the observations of the author—only in 7 to 8 per cent. It is a no less variable symptom of abdominal typhus than is diarrhœa, roseola, enlargement of the spleen, and when a typhoid condition is present.—*Inaugural Dissertation*, St. Petersburg, 1896.

Pathological Changes in the Skin in Scarlatina.—According to the investigations of PRESBRAGENSKI, the principal changes may be summed up as erythematous inflammation, especially of the papillæ, expressing itself by dilation of the vessels, emigration of red and white corpuscles, and sometimes by hæmorrhage and infiltration of the papillar part, with round and sometimes elongated cells. This inflammation is accompanied by slight œdema of the interstitial tissue in the papillar as well as the epithelial portion, the latter in Malpighi's stratum and the epidermis. In the first this swelling manifests itself by vacuoles in the cells, and in the second by distinct infiltration in the stradium floritionis.

The inflammatory symptoms are clearly expressed in all periods of the disease, but especially when the eruption appears. Deeper changes of the skin are considerably less: slight infiltration of round and elongated cells around the sebaceous and sudorific glands; dilatation of blood-vessels; sometimes emigration of red corpuscles in the sudoriparous glands, and slight changes of the epithelium itself of the latter, such as irregular infiltration and desquamation. Exceptionally necrosis of the epithelial cells occurs.—*Inaugural Dissertation*, St. Petersburg, 1896.

Italia.

PROF. F. MASSEI,
REDATTORE CORRISPONDENTE PER
LE LARINGOLOGIA E
RINOLOGIA.

Si prega di mandare tutti i giornali, libri, stampe, etc., sulle suggetti sopra nominate che vedono la luce in Italia al

PROF. F. MASSEI,
4, Piazza Municipio,
Napoli.

Bacteriological Researches upon Caseous Rhinitis.—GUARNACCIA has made bacteriological researches upon caseous rhinitis. These studies refer to a case observed by Massei in his clinic. Guarnaccia has demonstrated that the micro-organism found in rhinitis caseosa, which was so differently understood by Perier, Sabrazès, etc., is the streptothrix alba, or Foersterii, studied by Rossi-Doria, Cohn, and Gasperini. The author was able to cultivate it in agar, gelatin, bouillon, blood-serum, potatoes, and milk. Inoculations in animals were not successful. It is perfectly correct, in his opinion, to assume that the considerable amount of caseous matter is formed by the growth of the streptothrix, as is the case in muguet.—*Archivii Italiani di Laringologia*, No. 4, 1896.

The Efficacy of Subcutaneous Calomel Injections in Laryngeal Syphilis.—A case is reported by CHOSCA which unmistakably demonstrates the great efficacy of subcutaneous injections of calomel. Seven and one-half centigrammes ($1\frac{1}{8}$ grains) are injected daily; then an interval of several days is allowed to elapse before the injections are renewed. The patient, upon whom tracheotomy was to be performed, was dying of asphyxia. Other treatments, even subcutaneous injections of sublimate, had previously been resorted to without success.—*Archivii Italiani di Laringologia*, No. 4, 1896.

Clinical Notes and Lectures.

Carbide of Calcium in the Treatment of Uterine Cancer.—FLOERSHEIN states that the treatment of cancer by carbide of calcium consists in the careful introduction, by means of a speculum, of fragments of carbide of calcium into the bottom of the posterior *cul-de-sac*, followed by immediate tamponing with iodoform gauze. After twenty-four to forty-eight hours the tampons are removed and the fragments brushed with a copious injection of oak-bark solution. The dressing is renewed every four or five days. The general technique of the procedure is the following:—

1. All the protruding portions of the neck should first be removed with the scissors; curetting will then destroy all the friable masses until the sensation of healthy or nearly healthy tissue is experienced. The same operation should be made upon the vagina if the latter is secondarily affected. If the body of the uterus does not appear to be involved, one must be careful not to touch it with the curette; if it is affected, curettage should be followed by brushing with creasoted glycerin, camphorated naphthol, or a solution of tincture of iodine.

2. Hæmorrhage should be arrested by thermo-cauterization of the bleeding-points, which, in the case of cancer of the body, should also be made to include the interior of the uterine cavity. Tight tamponing with salolated gauze will complete hæmostosis, and should be kept in place during two days.

3. Injections should be made every day, either of the *liqueûr Labarraque* (a tablespoonful to a quart of boiling water) or of one of the following solutions recommended by Auvard:—

℞ Carbolic acid, ...	245 grammes (8 ounces).
Glycerin, ...	245 grammes (8 ounces).
Essence of thyme, . . .	10 grammes ($2\frac{1}{2}$ drachms).

A tablespoonful to one or two quarts of water.

℞ Salicylic acid, ...	1 gramme (15 grains).
Essence of rose-geranium, . .	5 grammes ($1\frac{1}{4}$ drachms).
Alcohol at 90°, ...	300 grammes (10 ounces).

A tablespoonful to one quart of water.

Other antiseptic injections may be substituted when the action of those above cited diminishes; for instance, sapon. coal tar (3 to 6 tablespoonfuls to 1 quart of water), tincture of benzoin, and various odorous essences, which may be used for vaporization in the sick-room, which should be frequently aired. The garment of the patient may also be vaporized.

4. From time to time an injection may be replaced by a tampon covered with Championnière's powder, which consists of powdered benzoin, iodoform, and eucalyptolized magnesia in equal parts.

Tonics should also be administered; cinchona-wine, tincture of kola, Fowler's solution, champagne, etc., may be given to keep up the strength of the patient.

Heart Disease and Pregnancy.—In support of his contention that the existence of heart disease does not in every case, as maintained by Peter, constitute a contra-indication to marriage, JACCOUD, of Paris, cites a case in which the patient had suffered from a long and severe attack of acute rheumatism before marriage, with signs of cardiac mischief. Two years afterward she married, and was able to go through three successive childbirths and one miscarriage without any distressing cardiac symptoms. After her fourth pregnancy she began to feel short of breath, and after the fifth delivery symptoms of acute asystole, with dyspnœa and hæmoptysis, set in. There was no doubt that permanent damage to the heart had resulted from the repeated pregnancies, and a double mitral lesion with tricuspid incompetence was diagnosed. Pregnancy always tends to cause serious disturbances of the cardio-pulmonary circulation, and to throw additional work on the heart. Patients who suffer from mitral lesions, which rapidly affect the lesser circulation, frequently manifest toward the fifth or sixth month "gravido-cardiac" symptoms,—namely, dyspnœa and hæmoptysis. Still it is obvious that a diseased heart up to a certain point may suffer no inconvenience from pregnancy. A too hard and fast line should not be drawn in advising or withholding consent to marriage. The wishes and ideas of the patient should be considered, and also the depressing and injurious effect upon the heart of withholding consent. The degree of the lesion and the absence or presence of gravido-cardiac symptoms should be noted, the latter forming a decided bar to marriage, though the effect of treatment upon this condition should determine the final decision. The occupation and surroundings of the patient, the possibility of her taking prolonged rest if necessary, should be considered. A milk diet is of great importance; 2 or 3 litres (quarts) should be taken daily from the second or third month of pregnancy. This is a powerful aid to the circulation by reason of its diuretic action, and not only are the gravido-cardiac symptoms warded off, but the appearance of albumin in the urine is prevented. —*Semaine Médicale*, September 11, 1896.

The Causes of Death After Laparotomy.—FRITSCH, of Bonn, at the Congress of German Scientists and Physicians, reviewed the causes of death after operations involving laparotomy.

The most important organ is the peritoneum, where the physiological and pathological changes are very rapid. The time required for adhesion to take place is represented by minutes rather than by hours. Cocci are rapidly swept from the peritoneum into the blood and destroyed; but for cocci to become harmless three things are necessary: 1. They must not be in too great a quantity. 2. An undisturbed circulation and a healthy heart are necessary, while a lengthened operation, chloroform narcosis, loss of blood, and cooling injure the circulation. Possibly, also, the hæmoglobin and the chemical quality of the blood have to be taken into account. 3. The functions of the tissues—here the peritoneum—must be normal. The cooling is of less moment than the contact with the air and the altered pressure after opening the abdomen. The injury thus caused is often visible to the eye. The injury to the peritoneum is the greater the more roughly and improperly it is treated. Even without direct infection the operation might be dangerous. It must not be forgotten also that cocci accidentally introduced or coming through from the intestines might under these circumstances find conditions suitable for their growth. Generally, however, the weakened intestines recover their tone in a few hours. If, therefore, after twenty-four or more hours the heart is strong and the pulse is good there is no danger. But with a weak heart and a quick pulse the normal function of the bowel is not restored. Independent of infection, there are two conditions closely connected with each other that are dangerous,—viz., weakness of the heart and injury to the peritoneal and intestinal functions. Avoidance of infection is not alone important; the maintenance of the general and local power of resistance is of equal moment. Patients on whom laparotomy has been performed do not die because they become septic; they become septic while they are dying.

Myotomy is more fatal than ovariotomy because it takes longer, and the results become better as we learn to operate better.

Self-deception is an element of importance to be borne in mind. Every operator adopts some peculiar method of procedure, and as he improves as an operator his results improve also, until he comes to believe that his success is due to his peculiar methods. For himself his methods are really the best; whether for others this may be questionable.

The course in unfavorable cases is the following: The patient awakes after the operation already distressed. The breathing is rather heavy, the bandage pressing heavily (the binding is well borne in favorable cases, as a rule). The characteristic symptom is the cardiac weakness, the quick, feeble abdominal pulse being always pathognomonic. The abdomen is distended, the countenance pale; there is thirst, and vomiting is frequent. The temperature is normal. Tympanitis increases and the pulse becomes worse. These represent the symptoms of ileus, although there is in reality no obstruction. They may be recognized as peritonitic symptoms, but there is no purulent peritonitis present, no sepsis, for there could be sepsis without fever. These cases often get well. With and without suitable treatment the distressing symptoms may cease. If this is not the case, on the second or third evening there appears a slight fever that increases *sub finum vitæ*. In any case the most important symptom is the cardiac weakness, and not the fever.

If his views were correct, at least for many cases, the conclusions to be drawn as regarded practice are that, in cases of weakened or weak heart, in thrombosis after pneumonia, after influenza, etc., we should not operate, but wait. Before operation, debilitating preparation, such as starving, or powerful purgatives are contra-indicated. The technique must be good, the after-treatment very carefully conducted, washing out of the stomach, warm enemata, tonics subcutaneously, quinine, etc., being useful. A good technique, skill, and experience are very important as regarded results.—*Medical Press and Circular*, October 28, 1896.

Measurements of the Appendix.—In 150 cases of post-mortem examinations, C. J. Ringwell, of Minneapolis, found the weight of the appendix to vary from 2½ to 9¾ inches. Only two came above the general measurements,—one 6½ and the other, the longest he has been able to find any record of, 9¾ inches.

Both of these extra-long appendices were found in males; the cana communicated freely with the cæcum; they were almost free, having only a short mesentery; contained some hardened fæcal matter; otherwise were in an apparently healthy condition.—*Medical Record*, July 18, 1896.

Percussion of the Vertebral Column.—Bechterew draws attention to the diagnostic importance of percussion of the sacral region in some cases, as shown by the following instance: A patient was admitted under his care with symptoms of compression of the cauda equina. There was plantar and perineal anæsthesia, spontaneous pain in the joints, etc., pain on percussion of the sacral region, and the sphincters were affected. The history was that the patient had suffered from a severe contusion in the lumbar region in falling from a horse eight months previously, and for the last six months the symptoms had been gradually increasing, till at the time the case came under observation there was considerable hectic. On account of the grave condition of the patient and his severe suffering it was decided to perform a laminectomy. This showed considerable caries of the sacrum with caseating material compressing the cauda. After the operation the anæsthesia and pain disappeared, but the condition of the patient prevented his ultimate recovery. Post-mortem examination showed tuberculosis of the sacrum, suppurative prostatitis, and tuberculous pyelitis. During life percussion of the sacral region gave a marked dull note, while in the healthy condition percussion of the triangular area which has for its base the upper part of the sacrum and for its apex the coccyx should give a slightly resonant note. In the case just quoted the dullness corresponded exactly with the tuberculous mass which was found post-mortem.—*British Medical Journal*, October 24, 1896.

Retrodisplacements of the Uterus.—E. E. Montgomery, of Philadelphia, recommends the following measures:—

1. In recent cases, with a freely movable uterus, the medicated tampon or pessary. In many cases the former will be required as a preparation for the latter.

2. In recent cases with a plastic exudate and adhesions (when pus-tubes can be excluded), massage supplemented by the medicated tampon and restoration of the mobility of the uterus followed by the use of the pessary.

3. In chronic cases, with a movable uterus, curettement, followed by suturing the round ligaments in front of the uterus through an anterior colporrhaphy.

4. When the displacement is complicated by disease of an ovary or tube, curettement, followed by abdominal incision, treatment of the affected appendage, and fixation of the uterus to the abdominal wall.

5. When there exist adhesions without serious tubal or ovarian diseases, curettement and shortening of the utero-sacral ligaments after separation of the adhesions through the posterior vaginal incision.—*Medical and Surgical Reporter*, October 10, 1896.

Bullets in the Brain and the Rœntgen Rays.—A. EULENBURG (*Deut. med. Woch.*, August 17, 1896) relates two cases in which it was possible to localize bullets in the intra-cranial cavity by means of the X-rays.

Case I.—A man, aged 18, accidentally shot himself in the head with a revolver. The bullet entered 3½ centimetres above and 2 centimetres in front of the attachment of the ear. There was complete unconsciousness until the following morning. On the third day a left-sided homonymous hemianopsia developed, and then a left hemiplegia. The bladder was temporarily paralyzed. The hemianopsia disappeared on the tenth day, and the hemiplegia gradually got better, with the exception of the lower part of the leg. The patient was lame, but could walk. At the end of the seventh week Eulenburg found the lower face muscles weaker on the left side than on the right, and also the left arm weaker than the right. The gait was faltering, and the left leg stiff. Movements of the foot and lower leg were only just possible. Sensation was considerably affected. There was pain in the back of the head. Progressive improvement ensued. Eulenburg thought that the bullet had penetrated to the right of the sella turcica, injuring the right optic tract and the right crus. By radiography Buka showed that the ball was in the middle fossa of the skull to the right of the middle line.

Case II—A man, aged 33, attempted suicide ten years ago. The revolver wound was in the hinder part of the right temporal region. At first there were signs of intra-cranial pressure. For the first four years only slight symptoms were noted. Attacks of pain in the head supervened, and the patient thought that the bullet must still be present. He was then in an asylum for five years, and discharged as incurable. After his discharge he seems to have been able to work. When seen by Eulenburg the man was pale and wasted. Hardly a trace of bodily or mental symptoms could be made out. There was occasional headache in the right supra-orbital and temporal regions. There was thus no clinical evidence that the bullet was still present. It was, however, shown by Buka, by means of the Rœntgen rays, that the bullet was situated in the middle fossa of the skull behind the right orbital fissure.

BRISSAUD and LONDE (*Sem. Méd*, June 24, 1896) report a case in which a man had been struck by a revolver bullet (calibre 7 millimetres) in the middle of the left frontal eminence on August 4, 1895. Various symptoms followed, and finally a spasmodic left hemiplegia of both limbs and the face remained. The upper fibres of the facial, the motor oculi, and the masseteric nerves were not involved. The Rœntgen rays showed the outline of the skull, the frontal eminence and sinus, the maxillary sinus, petrous and malar bones, zygoma, orbital cavity, etc. The bullet was seen situated in the posterior region at the level of the second temporal convolution, probably above the tentorium. This position corresponded exactly with the direction of the track deduced by the resulting paralyses. The chief interest, besides the exact localization of the missile, consists in the fact that the bullet, being in the temporal region, could not be the cause of the hemiplegia. The latter was due to the section of fibres met with by the bullet, —that is, it had a capsular, not cortical, origin, and therefore could not have been benefited by any operation. An exposure of an hour and three-fourths was given, and the image would have been still clearer, but for a slight clonic movement of the head.—*British Medical Journal*, October 24, 1896.

The Use of Cold in Fevers.—H. A. Hare in a clinical lecture strongly advocates the application of cold in the reduction of fever. The author agrees that none of the organs of the body are strained in the effort at eliminating foreign materials, nor are their functions perverted by the presence in them of powerful remedies. On the contrary, the proper application of cold, associated with active rubbing of the skin to bring the blood to the surface, improves the circulation all over the body, increases nervous and circulatory activity, produces an elasticity of the blood-vessels which is destroyed by the use of drugs, and increases the action of the kidneys,—the organs which eliminate from the body most of the impurities. Although it would seem inconsistent to state that fever is a protective process and that the use of cold for its reduction should be advocated, in reality they are not so. There is a great difference between stopping oxidation processes by the use of drugs and abstracting heat from the body by the use of cold. When cold is used heat-production probably goes on with even greater rapidity, at least, after a brief time. By the bathing the bodily temperature is prevented from rising to the point at which the fever would be dangerous in itself, while at the same time the poisons produced by the disease are more rapidly burned up by the increased rapidity of oxidation. In other words, the application of cold simply increases the draught and so burns up the refuse more rapidly than before.

These conclusions are not merely theoretical ones. Careful experiments by Liebermeister and other investigators in this line prove that in many instances leucocytosis is markedly increased by the use of cold, and it is a well-known fact that by its use internal and external congestions are avoided, which, if they came on in full force, would seriously imperil the patient's life.

The manner in which the cold should be used in the reduction of fever is of the utmost importance. Some observers claim that fever, particularly typhoid fever, must always be reduced by actually placing the patient in the bath-tub, the water of which is at a temperature varying from 70° to 80°, or even lower; but it has always seemed to me that equally good and, in all probability, better results could be obtained if the use of cold were fitted to the case, just as the dose of digitalis or any other drug is fitted to the case. No one would think at the present day of asserting that every case of heart disease requiring digitalis as a cardiac tonic should receive exactly twenty drops of the tincture three times a day, but the common assertion would be that the dose of digitalis should vary with the necessities of the case. If, therefore, by means of careful sponging, or the use of water with friction, at a temperature of 85° or 90°, you can reduce a patient's temperature within a short time to 100° or 101°, surely this method is sufficient for the case. On the other hand, if colder water is required, it must be used, and the time of its application prolonged in direct proportion to the degree with which the fever resists treatment. And, finally, if repeated sponging with ice-water or with water at 60° or 70° fails to reduce the temperature, then it will be necessary to place the patient in a bath and perhaps to keep him there, rubbing him all the time until his fever is properly reduced. There is no such thing in medicine in connection with the use of drugs as recommending one definite dose for every case of any disease, and there is no such thing as a correct recommendation of one temperature or one method of the application of cold to every case of a given disease. To be successful practitioners you must make your "punishment fit the crime," or, in other words, you must make your remedy and your dose fit your case just as the tailor makes a garment fit each man.

As regards the comparative value of antipyretic drugs and cold sponging or bathing in the treatment of non-infectious fevers, such as are represented by sunstroke, clinical experience has proved that under these circumstances the antipyretic drugs possess little value, and that we must always rely chiefly upon cold bathing for the relief of patients suffering from thermic fever.—*Therapeutic Gazette*, October 15, 1896.

Hypnotic Effects of Pellotine.—F. JOLLY reports clinical tests in forty cases with pellotine muriate introduced by Heffter, of Leipzig. In one-half of these cases the drug was administered during the day, either by mouth or subcutaneously; doses of ⅓ grain (0.02 gramme) caused languor and sleepiness in quiet patients, but usually this effect followed only after ⅗- to $\frac{9}{10}$-grain (0.04 to 0.06 gramme) doses,—causing several hours' sleep within half to one hour after administration. In some cases the pulse-rate was decreased, in others not at all, and only at the beginning of sleep. In painful affections (lancinating pains in tabes, neuritis, and ischias) sleep was also induced, but an anæsthetic effect was only occasionally noted before and after sleep. In excitable and delirious patients the above-mentioned doses were insufficient; even 2-grain (0.12 gramme) doses did not produce sleep, but had a calming effect—lasting all day—on the patient.

In twenty cases the drug was administered at night as hypnotic, and ¾- to 1⅕-grain (0.05 to 0.08 gramme) doses were found to equal in effect 15 grains (1 gramme) of trional or 22 to 30 grains (1½ to 2 grammes) of chloral.

Of side-effects, excepting the inconsiderable slowing of pulse-rate, a few patients exhibited giddiness and a feeling of unrest before sleep ensued;

a few also complained of similar feeling upon awakening in the morning. In several cases the hypnotic effect was not produced, but in these other hypnotics had also proved ineffectual. In no instance were serious side-effects noted.—*Therapeutische Monatshefte*, June, 1896.

Treatment of Eclampsia.—MANGIAGALLI, in an elaborate paper, reviews the different methods employed for the treatment of this disease. Obstetric treatment is that preferred by him, medical means being regarded as preparatory or adjuvant. Preventive therapeutics are very beneficial in removing the conditions which are the expression probably of the auto-intoxication, and consist in milk and intestinal disinfectants, diuretics, etc. The medical treatment (bleeding, purgation, morphine, chloral, chloroform, veratrum viride, or diaphoretics) is purely symptomatic, but in his opinion is the only one possible in post-partem eclampsia, and in other conditions is a valuable aid to the obstetric intervention. Bleeding, followed by the subcutaneous or endovenous injection of normal saline solution, has much to recommend it, but it has not been employed sufficiently often to permit a just estimate of its value. The speedy evacuation of the uterus constitutes the most important means of treating eclampsia. In intra-partum eclampsia it is a good rule to terminate labor when the conditions permit, and even to anticipate these by means of multiple incisions of the cervix. In eclampsia in pregnancy the induction of labor by the rupture of the membranes is indicated along with the use of morphine, or chloral, or veratrum viride in large doses. If these means fail, then forced dilatation of the cervix is to be preferred to the deep incisions of Dührssen. In some very bad cases even Cæsarian section may be a justifiable operation, especially if the fœtus be full time and alive. Every operative intervention must take place with the patient deeply anæsthetized.—*Annali di Ostet. e Ginecol.*, September, 1896.

Asepsis of the Nasal Cavities.—After an elaborate review of St. Clair Thomson's, Wurtz's, and Lermoyez's papers, PIAGET relates the numerous experiments which he has conducted for the study of bacteria of the nose. In the normal state the nasal cavities are free from microbes, except the anterior part and vestibule. The culture of nasal mucus collected in the remote parts is sterile; the nasal cavities are normally aseptic. That asepsis is the result of the structure of the canal, of the ciliated epithelium, and especially of the bactericidal properties of the nasal mucus. That bactericidal action is absolute for carbuncle bacteria, very marked for Lœffler's bacillus, and less marked for staphylococcus and streptococcus. This asepsis explains to a certain degree the immunity of nasal operations.

KLEMPERER, of Strasburg, does not agree with the authors named, but maintains that in healthy noses, while it is true that bacteria are to be found in quantity only in the vestibule, still no part of the nose is germ-free. Let the anterior parts of the nose be thoroughly sterilized with perchloride of mercury and washed out with sterilized water; then wipe out the parts higher and deeper in with sterilized cotton-wool swabs. These (the swabs) always bring away a few germs, from which two, three, four, or more, frequently six, eight, ten colonies can be cultivated.

Klemperer cannot confirm the statements of Wurtz and Lermoyez as to the bactericidal properties of nasal mucus. Unlike these authors, he experimented not with anthrax bacillus, but with the bacteria which he had previously cultivated from the nose whose mucus he was testing. At first they did not grow well, and even diminished to some extent in number, but soon grew accustomed to the mucus and multiplied in it. Extinction was never observed.—*Journal of Laryngology*, November, 1896.

Recent Suggestions in Therapeutics.

Benzonaphthol and Salicylate of Bismuth in Summer Diarrhœa.—SOLOMON SOLIS-COHEN states that he has never met with a better mixture for disinfecting the digestive tube than one composed of equal parts of *benzonaphthol* and *salicylate of bismuth*, with or without the addition of *Dover's powder*. A child 6 months old may take 3 grains (0.20 gramme) of the two former ingredients,—*i.e.*, 1½ grains (0.10 gramme) of each. It is important to suspend the milk diet during the active treatment. *Barley-water* in small quantities may be substituted. The use of the various flours, which readily ferment in summer, and which contain toxins, should also be discontinued. Another error which must be avoided is the administration of astringents: kino or tannic acid. The physicians prescribing the latter remedies assist the disease rather than the patient. (*Revue de Thérapeutique*, November 1, 1896.)

Carbolic Acid in Influenza of Children.—S. H. DESSAU, of New York, recommends the internal administration of *carbolic acid* in cases of a mild irregular type of influenza. Finding that cases of this kind did not recover so rapidly as he expected under the ordinary sudorific and expectorant treatment, he tried carbolic acid, and after an experience of 300 cases he pronounces it very efficacious. In the cases referred to there was a dry cough, worse at night, with signs of slight bronchial catarrh, alternating sometimes after chills with coryza and diarrhœa. The annoying cough was often relieved in two or three days, always within a week. The dose given was a teaspoonful of a 1-per-cent. solution for a child of 5 years, and it was administered every two hours until decided improvement was noticed, and afterward at longer intervals. Only in one case did nephritis occur, and Dessau was inclined to attribute it to the influenza, and not to the carbolic acid. (*Medical Record*, September 12, 1896.)

Chlorate of Soda in the Treatment of Cancer of the Uterus.—E. DUVRAC, in a thesis fully analyzed in the *Semaine Médicale*, July 15th, describes a method of treatment which was first used by L. Boucher, of Rouen, in the palliation of uterine cancer with good results. The method consists in the internal administration of *chlorate of soda* in the manner in which Brissaud employs that drug in the treatment of cancer of the

Chlorate of Soda in the Treatment of Cancer of the Uterus (*continued*). stomach, combined with the local use of the same substance employed as a dressing at the neck of the uterus. Internally it is given as follows: ℞ *Chlorate of soda*, 5 drachms (20 grammes); *syrup of orange-flower*, 8 drachms (32 grammes); *distilled water*, 3 ounces (90 grammes). Mix. Two to 8 tablespoonfuls of this mixture to be taken daily. It is well to make the patient begin with 2 tablespoonfuls a day, and to increase the dose rapidly up to a total amount of 128 grains (8½ grammes) of *chlorate of soda* in the twenty-four hours. For the local applications the following powder is used: ℞ *Chlorate of soda*, *subnitrate of bismuth*, of each 2½ drachms (10 grammes); *iodoform*, 1 drachm (4 grammes). Mix. A small quantity of this is applied on a tampon to the cervix. Strips 6 inches wide and 2 inches long of sterilized tarlatan, impregnated with 1 part of *iodoform*, 20 parts of *chlorate of soda*, and 20 parts of *glycerin* may also be used. These are squeezed out, then cut into pads about 4 inches in length, and tied around the middle with a silk thread, with which the tampon can be removed from the vagina; each of these pads contains about 15 grains (1 gramme) of *chlorate of soda*. If symptoms of iodoform poisoning occur, tampons of salolized cotton steeped at the time of dressing in a 20-per-cent. watery solution of *chlorate of soda* should be substituted for those described. Lastly a vaginal injection of a quart of boiled water, holding in solution 150 grains (10 grammes) of *chlorate of soda*, should be given every day. (*British Medical Journal*, October 31, 1896.)

Chlorosis.—Bloom, of Philadelphia, recommends the following formula, which has been of signal benefit in a number of cases in which other measures failed: ℞ *Manganese and iron lactate* (Merck) 96 grains (6.4 grammes); *oxalic acid*, C. P., 4 grains (0.28 gramme); *strychnine sulphate*, 1 grain (0.07 gramme); *compound extract of colocynth*, 16 grains (1.07 grammes). Mix and make 32 capsules. Dose: One capsule two hours after each meal. In occasional cases nothing is as useful as arsenic; a preferred combination is *manganese arsenate* in doses of $\frac{1}{10}$ grain (0.006 gramme), three times a day, after meals. (*Philadelphia Polyclinic*, October 17, 1896.)

Citrophene.—Homberger, of Breslau, repeated the experiments of Benario and other authors. He gave his patients doses of 7½ grains (0.50 gramme), four times a day on an average. The result obtained in a case of migraine which had resisted all remedies was remarkable. Unfortunately at the end of a certain time the medicine no longer had any effect. The author resumes the results of his practice as follows: Citrophene is a good antithermic, having no unpleasant epiphenomena; it is likewise a good antirheumatic and antineuralgic, and is distinguished from its *congénères* inasmuch as it increases the appetite in a large number of cases, and is easily taken, owing to its pleasant taste, which resembles that of citric acid. (*Revue de Thérapeutique*, November 1, 1896.)

Cocaine Poisoning: Magnan's Symptom.—Rybakoff, of Moscow, insists on the diagnostic value of the symptom of chronic cocaine poisoning described by Magnan,—*i.e.*, an hallucination of common sensation. The patient complains of feeling some foreign body under the skin. In some cases the foreign bodies felt were like grains of sand, in others slightly larger; generally they were described as more or less rounded, and gave rise to complaints of microbes, worms, crystals, etc., situated just under the skin. While other symptoms of chronic cocaine poisoning occur also in alcoholism and with other poisons, Magnan's symptom seems to occur only with cocaine. It has, therefore, a real diagnostic value, especially in cases in which the patient is unwilling to admit having used cocaine. Where cocaine is extensively used in surgery and dentistry, the appearance of Magnan's symptom is a valuable indication for the immediate cessation of the drug. Korsakoff reported a case in which a woman, suffering from multiple neuritis complained of "worms in the skin." On inquiry it was found that vaginal tampons containing cocaine had been freely used. The omission of these was followed by amelioration of the symptom. (*Neurol. Centralbl.*, August, 1896.)

Eclampsia: Method for the Induction of Parturition.—Drejer, of Christiania, recalls the fact that in puerperal clampsia, the chief aim is to empty the uterus of its contents,—that is to say, to terminate the confinement and delivery as quickly as possible. With this end in view, he recommends the following procedure, which may be easily carried out by any practitioner, and which the author has used successfully in three cases, two of which were primiparæ. Having first placed the patient under profound anæsthesia, the cervical canal is dilated, first by means of Hegar's graduated sounds or some other dilator and afterward with the fingers, until the orifice has attained a diameter of three centimetres. Podalic version, according to the Braxton Hicks method, is then practiced and one foot extracted. This done, the uterine orifice is again dilated by separating its edges on one side by means of the child's leg upon which the hand of the operator exerts (the foot being already extracted from the wound) energetic lateral pressure, and on the opposite side with the hooked index of the other hand. When dilatation of from eight to ten centimetres has thus been obtained, it only remains to extract the child. As soon as the umbilical cord has been severed the placenta should be detached and the uterus compressed with the two hands for about an hour; this compression suscitates the uterine contractions, preventing any serious hæmorrhage. (*La Semaine Médicale*, October 31, 1896.)

Enuresis.—McKee, of Philadelphia, in many cases of enuresis noted the fact that the majority suffered from marked nutritive disturbances. One showed prominent rachitic deformities, while another suffered from organic heart disease, with frequent attacks of syncope. Gastro-intestinal disease was exceedingly common. In comparatively few cases can the

Enuresis (*continued*).

disorder be attributed to reflex causes alone. Even where there are no gross evidences of malnutrition, the metabolic activity in the sensitive nerve cell is probably disturbed. Hence, *strychnia* is recommended, on the whole, as the most valuable drug. A study of individual dietetic needs is most important in every case. (*Philadelphia Polyclinic*, October 17, 1896.)

Pain After the Extraction of Teeth.—*The Dental Office and Laboratory*, vol. x, No. 4, gives a comprehensive review of the various methods that are of use in allaying the intense pain sometimes following the extraction of teeth. All cases are not relieved by any one remedy; the writer therefore publishes the remedies which have been suggested from time to time. *Nitroglycerin*, a 1-per-cent. solution, a single drop in a half glass of cold *water*; two drops of *amyl-nitrite* for three or four seconds, carefully inhaled, the inhalation being followed by complete rest for five minutes. Fletcher's *carbolized resin*, which is composed of *resin*, *carbolic acid*, and *chloroform*, may be employed. The *resin* may be dissolved in the *chloroform* to saturation in a half-ounce vial, and 10 drops of *carbolic acid* added. It is also an excellent styptic. *Chloroform*, 1 part, and *tincture of pyrethum*, the combination being placed on cotton and introduced into the socket. After cleansing the socket with *phénol-sodique* the following may then be applied on a loosely-rolled pledget of cotton: ℞ *Glacial carbolic acid*, 2 drachms (8 grammes); *liq. potassa*, 1 ounce (30 grammes); *water*, 6 ounces (180 grammes). Mix. (From *Gorga's Dental Medicine.*)

℞ *Alcohol* (best), 1 ounce (30 grammes); *chloroform*, 2 ounces (60 grammes); *sulphuric ether*, ¾ ounce (23 grammes); *gum camphor*, ½ ounce (15 grammes); *tincture of opium*, 1 drachm (4 grammes); *oil of cloves*, ½ drachm (2 grammes). Applied in the socket on a pledget of cotton. (T. B. Welch.)

℞ *Camphor*, 1 drachm (4 grammes); *chloroform*, 2 drachms (8 grammes). Mix. Applied to socket on cotton. *Chloroform*, *tincture of aconite*, equal parts. Applied to socket on cotton. ℞ *Morphia*, 6 grains (0.40 gramme); *tincture of aconite*, *chloroform*, *alcohol*, of each 1 fluidounce (30 grammes). Mix. Applied on cotton in the socket. Relief is often obtained by heat,—a dry hop-poultice being held next to the cheek. An easy remedy is to cleanse the socket with a swab of cotton wound around a match-stick, so as to remove all blood-clots, and to syringe the socket well with hot water. The septum in the socket next the adjoining tooth is sometimes fractured in the effort of extraction, and little spiculæ of bone remain within the socket, keeping up irritation. These should be removed if large enough to be seized with the forceps, or syringed out with hot water if too small. The hæmorrhage is suppressed as much as possible and cotton moistened with *phenated comphor* is then introduced into the socket.

E. Sjoberg, of Stockholm, states that among the various remedies which are used for quieting the after-pain of tooth extraction, with or without resection, there is scarcely anything found more reliable than *phenylic acid.* A warm solution—say, 3.5 per cent.—is injected into the bottom of the alveolus with an ordinary-sized syringe. Should the pain continue, *phenylic acid* alone is used, filling the alveolus, and employing for the purpose a syringe with a bent end. After a few seconds the superfluous fluid is removed with a taper made of blotting-paper. Either the pure phenylic acid or the strong solution is used; a napkin, reaching the edges of the alveolus, must be pressed to both sides of the same in order to protect the surrounding parts from excoriation.

℞ *Menthol cryst.*, 5 grains (0.35 gramme); *tincture of aconite*, 20 drops; *chloroform*, q. s. ad 2 drachms (8 grammes). This is to be applied on the gum over the seat of trouble with a pad of bibulous paper. (*Ohio Dental Journal.*)

I. H. MORGAN, of Salem, Va., recommends the washing out of the socket by syringing with hot *water*, to which a few drops of *carbolic acid* have been added; after ascertaining that there are no loose spiculæ of bone to act as irritants, cotton pledget saturated with ℞ *Menthol*, 1 drachm (4 grammes); *chloral hydrate*, 1 drachm (4 grammes); *gum camphor*, ½ drachm (2 grammes); *alcohol*, 1 fluidounce (30 grammes), is introduced. When the pain partakes of a neuralgic character, *antikamnia* in 3- to 5-grain doses, *phenacetin* in 5- to 10-grain doses will generally give relief. The face may be bathed with a liniment of ℞ *Laudanum*, 2 fluidrachms (8 grammes); *tincture of capsicum*, ½ fluidrachm (2 grammes); *spirits of camphor*, ½ fluidounce (15 grammes); *oil of sassafras*, 2 fluidrachms (8 grammes).

In reporting a case of twelve days' pain after extracting a tooth to relieve periostitis, BENNETT (*Journal of the British Dental Association*) states that relief was finally and instantly obtained by passing a Paget knife into the socket and cutting across the nerve.

Piperazine in Gonorrhœa and Purulent Cystitis.—TISON and ATTAIX have noticed that piperazine has a rapid curative action upon acute and chronic gonorrhœa as well as upon purulent cystitis. It is generally administered in daily doses of 10 grains (0.60 gramme) in a little Seltzer or any other water which is sufficiently gaseous to form bubbles. Some physicians have considerably augmented this dose, which will, however, be found to be sufficient. (*Gazette Médicale de Strasbourg*, October 1, 1896.)

Salophene in the Treatment of Sciatica.—Having convinced himself of the genuine efficacy of salophene as an antirheumatismal remedy and as an analgesic, CAPPELARI resolved to try this remedy for sciatica, and describes the results obtained in four cases subjected to this treatment as marvelous. The first case reported by the author was that of an old man of 70, who had suffered from sciatica four weeks. Various remedies had been tried in vain. The administration of 1 drachm (4 grammes) of *salophene* per day caused the disappearance of the pains at the end of several days. A relapse having occurred, the same dose given for six days resulted in the permanent disappearance of the

Salophene in the Treatment of Sciatica (*continued*).
morbid symptoms. In the second case the sciatica had existed three weeks and disappeared after six days' use of the salophene. In the third case the sciatica was first notably improved under the influence of the salophene, and afterward disappeared completely after a continuance of the remedy. In the fourth case the sciatica was cured at the end of five days after the administration of 1 drachm (4 grammes) of *salophene* per day. In none of these instances were any subsequent morbid phenomena observed by the author. (*Journal de Médecine de Bordeaux*, November 1, 1896.)

Whooping-cough Treated by Nasal Insufflations.—Since Michael suggested this method of treatment, Moizard has employed, with great benefit, nasal insufflations of antiseptic powders. He uses this powder: ℞ *Benzoin* (pulv.), 10 parts; *salicylate of bismuth*, 10 parts; *quinine* (sulphate), 2 parts. The insufflations are made five times a day. In a week, and less, the accesses of coughing are reduced in number and intensity and the cure is rapid. (*Jour. de Méd. et Chir. Pratiques*, August 10, 1896.)

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No. 28, RUE DE MADRID, PARIS, FRANCE.

(End of Editorial Department of Journal for November, 1896.)

GLYCO-THYMOLINE (KRESS) IN NASAL CATARRH.

Nasal catarrh is often a troublesome affection. In its incipiency, apparently a trivial ailment, it may be carelessly treated or entirely neglected. The result is that when a case is brought to the physician's notice it is apt to have assumed a more or less chronic character. Nasal respiration is obstructed by a thick discharge and by the presence of crusts.

An antiseptic and unirritant fluid, known as glyco thymoline (Kress), was recently brought to the writer's notice, and was satisfactorily employed in several cases. The fluid is best applied by means of a Bermingham douche, a cheap and convenient glass apparatus. The glyco-thymoline is diluted by three times or more its bulk of water, according to the age of the patient and the circumstances of the case.

A slender built 11 year-old boy, prone to attacks of catarrh of the throat and nose, had suffered for about ten days from a thick and abundant muco purulent discharge from the nose. The nasal passages were coated with thick crusts. Breathing through the nose was impossible, the voice was muffled, and there were frequent attacks of epistaxis. The use of glyco-thymoline, diluted, twice daily, had an excellent effect. Secretion diminished, crusts ceased to form, bleeding soon ceased, respiration became more free, and in a few days the trouble had disappeared. An equally good result was obtained in the case of a child, 2 years of age, in whom some coryza had been present for about two weeks, and of a lady attacked by an acute coryza, attended by headache and lassitude. A similar experience with several other cases of subacute and chronic nasal catarrh has shown that the local treatment by glyco-thymoline (Kress) is convenient and effective.— G. A. HEWITT, M.D., Philadelphia.

APOLYSIN.

One of the most puzzling questions which confronts a practitioner is how he can successfully treat a persistent neuralgia without employment of medicaments, which, even if they produce any materially beneficial results in the alleviation of the neuralgia, often are productive of bad effects in other respects. The *Deutsche medicinische Wochenschrift*, Berlin, of August 13, 1896, records a very successful treatment of a case of Dr. G. Greif, of Serkowitz, who relied wholly upon the use Apolysin. He tells us that he had a case of twelve years' standing. The patient was 39 years old; there was no special source to which this persistent neuralgia could be traced except the cause given by the patient that he had taken cold.

The history of treatment is very interesting On June 7, 1895, the treatment was begun as follows: 4, 5, and 7 o'clock, he received 15 grains of Apolysin. From June 8th to 21st, inclusive, he took 15 grains six times daily at three hourly intervals. From June 22d to 28th, inclusive, he took 15 grains four times a day at three hourly intervals, and June 29th to August 10th, 15 grains twice daily, making in all 6⅔ ounces of Apolysin.

The result was a continuous diminution of the intensity of the pain. By August 11th there was absolute cessation. One year later there had been no return of the pain. Other cases corroborate Dr. Greif's views.

A very beautiful souvenir, which revives that keen regret which all Americans must feel at the untimely decease of Eugene Field, has recently come to our notice. Under the title of "Field Flowers" there has been published a cloth bound book, 8 by 11, gilt edges, heavily enameled card-board, die stamped in gold and color from design by Stanford White, selected by St. Gaudens. This beautiful little book comprises about 40 pages, and contains some of the brightest gems from Eugene Field. These poems are embellished by original drawings from some of our most talented illustrators, such as F. Hopkinson Smith, Frederic Remington, A. B Wenzell, Alice Barber Stephens, Frank O. Small, A. B. Frost, W. A. Rogers, Harry Fenn, and E. W. Kemble.

The object of the publication of this souvenir is to secure a fund which will be equally divided between the family of the late Eugene Field and the fund for the building of a monument to the memory of the beloved poet of childhood.

The Monument Committee comprises some of the best known newspaper men of Chicago, including Joseph Medill, editor *Chicago Tribune*, H. H Kohlsaat, editor *Chicago Times Herald* and *Chicago Evening Post*. This is a most commendable object and the purchaser of this book will receive much more than the worth of his money. For sale by booksellers for $1 per copy, or can be ordered of the Eugene Field Monument Fund, 180 Monroe Street, Chicago. Ten cents extra should be added for postage.

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FRANCE.

ACADÉMIE DE MÉDECINE.

Researches Concerning the Action of Chloroform.—REYNIER continues to advocate chloroform, which he thinks is much more easily used than ether. Patients react very differently from its effects, but a pre anæsthetic examination of each patient will enable one to judge in advance what is likely to occur during chloroformization.

In a normal case the cerebral cells are first affected, then the medullary cells, and finally the bulbar. According to the more or less great resisting power of these various cells, fatal accidents may mark the early stages of anæsthetization. In alcoholics, whose cerebral cells are in a continual state of hyperæsthesia, delirium is observed, which may reach the stage of delirium tremens. In hysterical subjects all varieties of hysterical attacks may occur, even paralysis and syncope. The same is the case in epileptics. In morphinomaniacs only slightly intoxicated chloroformization is easily and rapidly accomplished; in others, on the contrary, it is more dangerous. In ataxic subjects the period of medullary excitement nearly always gives rise to reflexes which may arrest the respiration and heart-movements.

These accidents, which mark the beginning of chloroformization, may also occur at the end; therefore patients should never be left until completely awakened.

Tuberculosis in the Smaller Animals.—CADIOT read a paper from which he deducted the following conclusions:—

1. Tuberculosis in the dog, cat, and *psittacidæ* are, in the majority of cases, of human origin.

2. Tuberculosis in the dog is much more common than is at present believed; it may give rise, by inoculation, to external accidents, such as ulcers and fistulas, generally occupying the cervical region, of which the pus sometimes contains numerous bacilli.

3. Tuberculosis in the cat may be accompanied by similar lesions, also affecting principally the neck and the head.

While the tuberculosis of the *psittacidæ* is, in its various forms, identical with that of mammals, it is nearly always manifested by lesions of the skin, of the mucous membrane of the mouth, nose, or ear, and sometimes by ulcers of which the product of secretion is very virulent.

Facts abound which demonstrate with what facility tuberculosis may be communicated by the localities in which the germs are disseminated. All agents capable of disseminating these germs should be cited, and although the infection of man by tuberculous patients is rare, yet it is important that all factors should be known.

Société Médicale des Hôpitaux.

Opalescence and Lactescence of the Serum in Certain Cases of Albuminuria.—Achard stated that he had observed, in a consumptive presenting 10 grammes of albumin per quart of urine, lactescence of the serum such as that in the cases recently cited by Widal and Sicard. During the experiments, made with Lannelongue, concerning proteus infections the lactescent serum was found in a rabbit upon which inoculations of the microbe had been made in the vein of the ear, and which afterward presented a marked proportion of albumin in the urine. In other animals, under the same conditions, the experimenters were not able to note the same phenomenon.

Chyliform extravasation, in which there is frequently no fatty matter, resemble these cases. In one instance an albuminoid substance showing the reaction of casein was found; in a woman having ascites, due to some undetermined ovarian affection, a liquid of milky appearance was found, in which no fat was present, but containing albuminoid substances differing from those already observed. There were nucleo-albumin and globulin. The lactescent condition was apparently due to innumerable, very fine albuminoid granulations.

Widal stated that since his last communication was made he had been able to observe the serum of three patients with Bright's disease. In one case, in which there were 10 grammes of albumin, the serum was clear; in the other cases the serum was opalescent in one and lactescent in the other. In the latter case the lactescence, which was already present when the patient entered the hospital, became much more marked after several days. There were 1.50 grammes of albumin in the urine. Milk diet does not appear to influence this condition, for, in this instance, the serum was already lactescent before the milk diet was begun.

Variot reported that, in dogs in which he had made injections of antidiphtheritic serum, he found that the serum was lactescent, and that this lactescence appeared more pronounced at the end of five or six days. As these dogs were mostly fed with milk, he questioned whether this lactescence of the serum was due to the action of the antidiphtheritic serum or to the milk. In his "Treatise on Humors" Robin states that the serum may be lactescent in certain affections, such as cholera, and also in the physiological state.

WIDAL remarked that in dogs the serum is often lactescent, especially during digestion ; experimenters are, therefore, careful to let the animal fast for twenty-four hours before collecting the serum. He questions whether the dogs in which Variot observed this lactescent serum were albuminuric.

VARIOT replied that he had not noted the condition of the urine. The serum of these dogs presented the appearance of soapy water. With the microscope fatty globules could be seen ; ether caused the disappearance of the lactescence. In rabbits he was also able to note this lactescence after the injection of antidiphtheritic serum, but in a less pronounced degree.

ACHARD considered that this would seem to indicate the existence of two varieties of lactescence,—one due to fat and the other to fine albuminoid granulations.

WIDAL remarked that the older writers had already had this idea; personally he had never met with fat in the cases examined by him, but only with albuminoid substances.

Dermoid Cyst Expelled Through the Bladder.—LEGENDRE reported the case of a woman, 48 years old, who entered his service for the treatment of cystitis, and who had previously presented serious symptoms and had been treated for dothinenteritis. Upon her entrance into the hospital she voided purulent urine and suffered from intense vesical pain. Lavage of the bladder did not result in any amelioration of the symptoms. On November 9th the patient expelled during micturition a membrane composed of fetid sebaceous material and a large number of little, white hairs. Rupture of a sebaceous cyst in the vesical cavity had occurred. Two days later laparotomy was practiced and the cyst was found behind the bladder and adhering to the intestines. The cyst still contained putrified sebaceous matter and a quantity of hairs.

SOCIÉTÉ DE CHIRURGIE.

Treatment of Congenital Cysts of the Neck.—WALTHIER read a report on a paper by VERCHÈRE concerning a child which presented a congenital cyst at the level of the sheath of the cervical vessels and extending to the pericardium. The author considers that Verchère exaggerates the difficulties to be met with in operating upon growths of this kind. While these cysts are frequently connected with the larger vessels of the neck, they are also often easily detachable, particularly from the jugular vein. In studying the cases of total ablation of these cysts it will be found that the accidents resulting were of an infectious nature, but that no serious operative hæmorrhages were reported. With regard to the secondary sacs, it is impossible to open them through the principal cavity when they are small and in groups or bunches (like grapes) and they cannot be reached from the opening of the sac. Total extirpation has often been successful, and should be attempted except in cases of adherence which it is impossible to detach, and in those analogous to that of Verchère, in which there were prolongations which could not be reached, such as those extending to the pericardium.

Quénu fully agreed with Walthier. It is undoubtedly necessary to allow the prolongations of congenital cysts of the neck to remain, where they are inaccessible, but the entire sac should be removed whenever possible, even at the cost of a very difficult dissection. Walthier has not distinguished between the different walls of cysts. When they are merely serous, it may be sufficient to make a large opening, and to practice curettage and drainage of the sac; but, when one has to deal with a cyst with more or less cutaneous walls with sebaceous or pilous contents, it will be necessary to entirely remove them. The speaker cited a case in a young girl in which the sac contained hair and where it was absolutely necessary to remove the entire mass.

Kirmisson remarked that complete extirpation of serous cysts is not only possible, but advisable in the majority of cases. These tumors are in intimate relation with the vessels and sometimes have prolongations which necessitate the adoption of Verchère's procedure. In a case operated upon by the speaker, and followed by recovery, he resorted to the same method. The remarks made by Quénu, he considered, did not apply to the question as presented by Verchère. They referred to dermoid cysts, which are quite different.

Quénu wished to add that there are mixed cysts, and that his remarks had been in consequence of this fact, as well as the report of the case cited by him.

Intestinal Perforations in Typhoid Fever.—**Monod** gave an account of a case, which he had been called upon to treat three weeks previously, in which there was intestinal perforation. He performed a median laparotomy, which gave issue to a quantity of purulent serum and to a loop of thin intestine which was perforated. The latter was sutured, and after lavage and drainage of the stomach it was closed. Improvement seemed apparent during thirty-six hours, but the patient died. The autopsy revealed the fact that the suture had remained intact. In 1884 Leyden conceived the idea of surgical intervention during typhoid fever, and in 1890 Louis reported 11 cases with 11 deaths. Monod stated that his researches had attained a total of 35 cases, among which were 5 recoveries, but that if carefully examined it would be found that these 5 cases are far from being perfectly authentic, particularly those of Drs. Murphy, Hill, and Wagner. Only 2 appear to be undoubted,—1 in 1891 and 1 in 1895.

It may be stated that the intestinal suture remains intact, even in these fatal cases, but the patient is already in a state of semicollapse, and should be very carefully examined before it is decided to have him run the risk of a laparotomy. The perforation occurs in the centre of the peritoneum, and generally infects the latter. The perforations are often multiple, and even upon intervention it is not possible to find them all. A patient presenting intestinal perforation during typhoid fever dies, or is likely to die. If there were only a single chance of recovery (and there are two) it is imperative to give the patient the benefit of this chance, particularly if the conditions are at all favorable.

ROUTIER stated that, guided solely by the painful spot in a typhoid patient, he performed a laparotomy which disclosed two perforations which he was able to suture; he left the stomach open, but the patient, nevertheless, succumbed upon the tenth day to two new perforations. There is a difference between the perforations occurring at the beginning of typhoid fever and those presenting themselves during convalescence. The two cases of recovery reported were of the latter class.

SOCIÉTÉ FRANÇAISE DE DERMATOLOGIE.

A Typical Case of Lichen Scrofulosorum.—HALLOPEAU and BUREAU state that the intra-peritoneal inoculation of a fragment of skin affected by this eruption gave rise to negative results; the same was the case in all the similar experiments made up to the present time. It is, therefore, probable that this dermatosis, of which the tuberculous nature has been clinically determined, is not directly engendered by bacilli having emigrated to the pilosebaceous glands, but rather by toxins having emanated from distant centres.

Concerning a New Case of So-called Folliculitis and its Possible Relation to Tuberculosis.—According to HALLOPEAU and BUREAU, this affection is clinically characterized by the appearance in the deeper portion of the dermis of small nodules, which soon project and are surmounted by a vesicopustule, which ruptures and gives rise to a central umbilication. Their principal seat is the dorsal surface of the arms, particularly in the region of the joints. They leave cicatrices which are at first shiny, distinctly round or oval, and pigmented in the beginning, but afterward pale. The authors report a case in which there was both pulmonary and ganglionary tuberculosis; one of them has also seen this eruption in co-existence with erythematous lupus, the lesions of which were confounded with those of the folliculitis. Tennyson has twice seen the latter affection in connection with lupus; there would thus appear to be a genuine foundation for the assumption of the tuberculous nature of this dermatosis, which constitutes a clearly differentiated clinical type.

Oil-of-Cade Collodion.—GAUCHER presents a new collodion composed of acetone collodion, $\frac{2}{3}$; oil of cade, $\frac{1}{3}$.—*La France Médicale*, November 20, 1896.

Poisoning Due to Arsenical-Water Nasal Douches.—A case of arsenical intoxication was observed by VÉRITÉ consequent upon nasal irrigations with badly-made Bourboule water. The water, instead of running out of the opposite nostril, had been swallowed by the patient,—a child.—*La France Médicale*, November 20, 1896.

GREAT BRITAIN.

Midland Medical Society.

Sir William Broadbent, in his inaugural address, interestingly reviewed several of the more important questions in the domain of practical medicine.

The Use of the Ice-bag.—The author related some recent experiences in the use of this method in which he had followed the lead of his colleague at the St. Mary's Hospital, Dr. David Lees, the latter observer having tried it in the treatment of acute affections of internal viscera. He had, for example, tried the ice-bag largely in pneumonia. The results appeared to be encouraging; but it would have taken a very long time to convince the speaker that a definitely beneficial influence was exercised on the course of this disease by the local application of ice, had the experience applied only to pneumonia. Nothing can be more difficult than to form a just estimate of the results of a given line of treatment in this disease, as is shown by the fact that it has always been a favorite therapeutic battle-field, and that success has been claimed for every kind of treatment. One source of difficulty is that the attack usually terminates by crisis in from five to seven days, the period not being quite constant; and it is a temptation to put down the sudden fall of temperature and the striking improvement attending the crisis to the credit of the treatment which happens to be in use at the moment, especially if it come early.

A greater difficulty is in estimating the severity of an attack of pneumonia and the danger attending it, and this varies enormously in different cases and in different series of cases. One patient will certainly die; another will as certainly recover. The temperature, pulse-rate, frequency of respiration, separately or in combination, afford no safe basis of comparison between one case and another; with nothing remarkable in any of these criteria we may see at a glance that the patient is in extreme danger or that the prognosis is favorable.

The Ice-bag in Pericarditis.—But in pericarditis it is easier to follow the results of applying an ice bag over the heart. Having satisfied himself that no danger attended its use and that the effects were favorable, the speaker had tried it in every severe case he had seen for the last two years, now numbering six. All did remarkably well. In one, the patient, a young girl, was considered to be moribund when he was called to her; she had for some time been delirious and was barely conscious, the pulse could scarcely be felt, and the action of the heart was extremely feeble and irregular. In another the condition of the patient was hardly less serious; in both cases a despairing prognosis had been given. Improvement dated from the time the ice-bag was applied, and in his judgment it saved the patients' lives. A third very severe case recovered. The others were examples of rheumatic pericarditis presenting no unusual features of severity. In one, however, pericarditis relapsed on the premature removal of the ice-bag, and the relapse was complicated by pneumonia, which was also treated by the ice-bag. No effects whatever on the heart are now traceable, and the patient, a schoolboy, is allowed to play cricket, ride, and swim.

The Ice-bag in Pneumonia.—With regard to pneumonia, Dr. Lees had, by request, given the speaker the notes and chart of two cases in which, by early application of ice, the disease had apparently been cut short. Instead of a sustained high temperature for a week and a sudden critical fall to 95° or 96° F. (35° or 35.5° C), the temperature had fallen steadily from the moment when the ice-bag was applied. Dr. Lees gives the following directions for the use of the ice-bag in pneumonia :—

1. Apply the ice-bag over the dull area, and especially over the advancing edge of the consolidation.
2. If the area is large, use two bags at least, or three. Even young children may require two.
3. Expect to find a distant local effect (improvement of percussion-note, less bronchial breathing, looser râles) on careful physical examination, after the ice has been applied for twenty-four hours.
4. If fresh areas of consolidation develop, use additional bags. Four or even more may be needed in a bad case. The amount of the dose is as important as it is with drugs.
5. Take the temperature every half-hour for the first three hours, afterward every two hours.
6. Apply hot-water bottles to the feet and legs. For children supply these before the ice is applied.
7. Examine the physical signs carefully twice daily and shift the bags accordingly.
8. If pericarditis is present, place one ice-bag over the heart.
9. If temperature below 99° F. (37.2° C.), or hands cold, or lips bluish, remove the bags for an hour; then replace them, and use them for two- or three- hour periods, with one- or two- hour intervals.
10. If in a severe case there is distinct cyanosis and a rapid feeble pulse, consider whether leeches (in urgent cases venesection) would not relieve the right heart.
11. In all cases see that sleep is secured during the first three or four nights. If the relief afforded by the ice-bags does not suffice for this, give chloralamid or morphine.

Pneumonia treated vigorously with ice within twenty-four hours after the rigor may sometimes be aborted.

The Ice-bag in Appendicitis.—Good results, again, had also followed the application of the ice-bag in inflammation of the appendix cæci. This is easily understood from the accessibility of the part to external cold, and from the fact that, in more than one case in which the speaker has concurred in recommending operation on account of recurrent perityphlitis, the appendix has been found simply curled up, congested, and thickened, without concretions or other contents.

The Ice-bag in Sciatic Neuritis.—One more experience of the good effects of the ice-bag—and this a personal one—in sciatic neuritis. Some years since SIR WILLIAM H. BROADBENT himself had had a very sharp attack caused by an evening ride in a hansom on the seat of which there was snow. He was fourteen days in bed, at the end of which time the muscles of his right thigh had practically disappeared, and he stripped the epidermis in ribbons from the knee to the ankle along the outer side of the leg. He was lame and the limb was œdematous for four months. Last winter sciatic pain had again set in with tenderness in the nerve. It is not an easy matter to give up work, but, when œdema of the foot was added to the pain and lameness, he thought it time to capitulate, and he went to bed with a couple of ice-bags along the course of the nerve. The pain was at once relieved, and in thirty-six hours all tenderness was gone. By way of precaution, he only did morning work for a couple of days, and applied the ice-bag during the afternoon and night, after which he returned to full duty without a trace of pain or lameness.

Intestinal Sepsis and Hodgkin's Disease.—On more than one occasion he had given instances of effects traceable to intestinal sepsis. Other microbes besides the bacterium coli commune are present in the intestinal canal and apparently at times find conditions which favor their activity, and they may then produce ptomaines which are absorbed into the blood and give rise to serious symptoms,—headache, heaviness, torpor, and, in extreme instances, almost coma with subnormal temperature,—which are cleared off at once by two or three doses of calomel; or in other cases it is a persistent subfebrile condition attended with headache and depression which is so caused. Some of the abnormal and severe symptoms at times met with in the course of typhoid fever are, in his opinion, due to intestinal sepsis, and not directly to the typhoid bacillus or its products. Other micro-organisms find a suitable culture-medium in the fluids exuding from the inflamed Peyer patches and the intestinal mucous membrane, and the ptomaines which they generate may be deadly poisons.

The following case appears to me to be a new illustration of what may be done by bad gastro-intestinal chemistry: A very acute case of Hodgkin's disease came under his observation, two years since, in a gentleman aged about 52 or 53. The glands of the neck, axillæ, and groins rapidly attained a very considerable size, but these were eclipsed by the enormous development of the glands within the abdominal cavity. One mass, in particular, could not be disengaged from the liver in the neighborhood of the portal fissure and was carried with it in its movements. The patient was sent to Folkestone, where he was watched by Dr. Eastes. Arsenic was given in gradually increasing doses, and the advance of the disease appeared to be checked, but the strength steadily diminished. The patient was a chronic dyspeptic, and a serious aggravation of his weakness and suffering was obviously traceable to dilatation of the stomach with its attendant anorexia, flatulence and acidity, and frequent copious vomiting of offensive matters. With some difficulty he was persuaded to allow the stomach to be washed out, upon which not only were the symptoms directly due to the dilatation relieved, but to the astonishment of the attending physician the glands began to melt away with great rapidity. The mass projecting from under the liver detached itself from this organ, and its component glands fell apart; other masses in different parts of the abdomen (presumably mesenteric) resolved themselves into groups of glands not easily distinguished, and a little later in point of time a steady diminution of the cervical, axillary, and inguinal glands took place. With this the patient gained strength and color, and they were looking forward to a complete recovery, when the patient's mother-in-law, who was on a visit in the house, took influenza and died, and he also was struck down by this disease.

Without generalizing too far or too confidently from a single case, the conclusion is at least suggested that the glandular enlargement here was due not to infection by cellular elements carried from one to another, but to irritation by some toxic substance generated in the dilated stomach which excited active proliferation in the cells of the glands, beginning with those in immediate relation with the surfaces from which the irritant was absorbed.

Should confirmatory experience be obtained, new light will be thrown on the causation of, at any rate, one form of Hodgkin's disease. It will be worth while making a careful examination of all cases from this point of view.

A similar case had come under his observation since. All the glands were greatly enlarged and masses could be felt in the abdomen. There had been severe dyspeptic symptoms before the glands were affected, and the patient himself attributed his illness to tinned meat and bad food generally in South Africa. He refused, however, to have the stomach washed out and was in other respects unmanageable, and the disease proved rapidly fatal.

In all these instances of disorder due to the formation of some ptomaine or toxin in the gastro-intestinal canal the process is chemical, but there are numerous other effects of dilatation or distension of the stomach traceable to mechanical pressure or to reflex disturbance of the nervous system. One is vertigo, which may be very severe. There is no translation or revolution of surrounding objects, and the giddiness does not come with the suddenness of auditory vertigo, but the patient will stagger as if he were on the deck of a steamer, and may be unable to cross the room without clinging to articles of furniture, or may have to hold on to the bedstead on rising in the morning. One feature it shares with Ménière's disease, and that is that it may be provoked by various movements,—by looking up, by stooping and again on rising, by changing from the horizontal to the vertical position and *vice versâ*, and by turning in bed, especially toward the left side. An interesting point about this *vertigo a stomacho læso* is that it may be instantly relieved by the escape by eructation of a few cubic inches of gas. Apparently, therefore, it is a mechanical effect of overdistension, and yet this can scarcely be from pressure on the heart, since the pulse may be perfectly steady and good when the giddiness is at its worst and the face of normal color and expression. We must assume, therefore, that the probable cause of the vertigo is reflex disturbance of the cerebral circulation excited by the distension.

Dilatation of the Stomach and Asthma.—Other symptoms attributable to dilatation of the stomach, or in some cases perhaps to distension without actual and definite increase of its normal capacity, are sleeplessness and nocturnal attacks of asthma. Sleeplessness, bad dreams, and perhaps nightmare from indigestion are probably more or less a familiar experience to most people, but the special form of insomnia caused by dilatation of the stomach is that in which the patient drops off to sleep at once on going to bed, and then wakes up punctually at a given hour to sleep no more till near the time when he ought to rise. In these cases the sufferer may not be conscious of indigestion or flatulence. Digestion, indeed, as a chemical process may be little impaired, but the stomach does not take the trouble to pass on the whole of its digested contents into the duodenum, and fermentation takes place in the residuum with evolution of gas and acid which at a given time reach an amount fatal to sleep.

Sleeplessness, which has lasted for months and for which all the various soporifics have been tried, may sometimes be dismissed in a week by remedies which relieve the distension of the stomach. The following is a recent illustration :—

A gentleman, aged 39, consulted him on October 5th. Seven years previously he had broken down, and for two years had suffered from nervousness and sleeplessness, on account of which he had had to give up business and spend a long time abroad. After five years of good health he had again begun to suffer from sleeplessness in May, although he was free from worry and was leading an active out-door life. He had taken sulphonal in gradually-increasing doses, but without result. Almost every night he woke up after a short sleep and remained awake for the rest of the night; under the loss of rest his nerves were giving way. On examination the stomach was found to be dilated; sulphonal was forbidden, and he was ordered phosphate, carbonate and sulphocarbolate of soda with spt. ammon., tincturæ gentianæ co., chloroform, and peppermint; his diet was, of course, also regulated. On the 13th he called to report that he was sleeping well.

Nocturnal asthma coming on punctually at a given hour. not associated with bronchitis and emphysema, is not infrequently due to dilatation of the stomach, and may sometimes be put a stop to with equal promptitude by treatment of this affection. So, again, with palpitation. Symptoms, indeed, of whatever kind which observe this rule may be suspected to arise from dilatation or distension of the stomach.

Had he taken dilatation of the stomach as the subject of his address he would have enumerated, among the effects observed from time to time, epileptiform attacks, a peculiar nocturnal diarrhœa, and other less important symptoms.

Dilatation of the Stomach and Sudden Death.—One effect of a serious character, often overlooked, is more worthy of attention; this is sudden death. It is, of course, put down to fatty degeneration of the heart or to valvular disease when this is present; and, no doubt, some kind and degree of organic weakness of the heart exists. A strong, healthy heart does not allow itself to be finally stopped by the pressure of a distended stomach.

On the other hand, a heart which has been functioning efficiently up to a given moment, in spite of a certain degree of degeneration or dilatation, does not suddenly cease to beat of its own accord for no reason at all; and among the causes which bring it to a stand-still is the mechanical pressure of a distended stomach.

Nowadays we make the diagnosis of fatty degeneration of the heart with great confidence, and we also cure it; but personally he has to confess to old-fashioned difficulty and uncertainty. Symptoms and physical signs are sometimes met with in a quite young person which later in life would be extremely suggestive of fatty heart,—a short, weak pulse, an entire absence of apex-beat or impulse, and short, weak sounds; but he does not venture to conclude that advanced degeneration exists. Moreover, the causes which in youth give rise to such functional weakness of the heart may, at middle age or in advanced life, when the suspicion of fatty change would be more justifiable, have the same effect. A personal friend of his, at the age of 45 or 48, had the pulse and heart conditions above described, and one day while eating he turned ashy pale and became unconscious and his jaw fell. This looked very like advanced fatty degeneration, but he lived for fifteen years.

While imaginary disease of the heart is diagnosed and, being imaginary, is, of course, cured, dilatation of the stomach, which is often a source of real danger, is frequently ignored.

It is important to know that the patient, when the danger is greatest, is usually entirely unconscious of flatulent distension; there may be little inconvenience of any kind, or merely a sense of oppression and a difficulty of satisfying a desire for a good, deep breath. The pulse again, may be unaffected, or may be weak and hurried or irregular or intermittent. It may be said, indeed, that flatulence often produces its most serious effects when the subject is quite unaware of its existence. When it gives rise to pain or discomfort, what we are conscious of and feel are not the mere distension by gas, but the effort to expel it or pass it on. When, however, the recumbent position is assumed, so that the weight of the abdominal viscera is thrown against the diaphragm, or when the patient stoops or bends forward while sitting or kneeling, so that the chest is brought down upon the abdomen, the pressure upon the right side of the heart so occasioned may be sufficient to arrest its action,—another illustration of the apparent paradox that people rarely die of the disease from which they are suffering.

A few examples may be given. Some years ago he attended a distinguished artist who suffered from mitral stenosis. Compensation had broken down under the fatigue and excitement of a journey through Spain, and the consequent embarrassment of the circulation nearly proved directly and speedily fatal. By leeches applied over the enlarged liver, calomel purges, and other treatment, the venous stasis and overdistension of the right heart were overcome, and the patient so far entered upon convalescence as to sit up and to leave his room for a great part of the day. The speaker's visits had almost ceased, but the patient was still under the observation of his family medical man, when one morning, just after a good breakfast in bed, he became impatient with the nurse, and insisted on washing himself without her assistance. He sat up in bed with the basin between his knees, and at a given period of his ablutions leaned over it to wash his face and fell back dying. The pressure upward of the abdominal viscera during this movement, with the full stomach immediately under the diaphragm, brought the dilated and enfeebled heart to a stand-still.

In November, 1894, a gentleman, aged 73, whom the speaker had known for some time, but had scarcely seen professionally, consulted him, complaining of weakness and breathlessness on very slight occasion, even from a slight walk on the flat. He had returned about a fortnight previously from a journey across Canada, which he had borne very well and had enjoyed; after that he had had some days' shooting and had walked well. In the following week he had been conscious of shortness of breath when reading prayers in the morning, and three days before he was seen by the speaker he had turned back from an uphill walk to church on account of a sense of hollowness and weakness in the chest and breathlessness. The occasion of this visit was that he had had a recurrence of this on leaving his home that morning. The pulse was 90 instead of 60 (the usual rate with him), large, and tense. There was no apex-beat or cardiac impulse, but the sounds were fairly good. The abdomen was distended, and the stomach-resonance came up to the fifth space and extended over a very large area; it was evident that the upward displacement of the heart with the pressure upon the right ventricle was the cause of the variable faintness and breathlessness. He went from the speaker's house to the city, transacted business, and had lunch, and in the afternoon took a long railway-journey, arriving at his country-seat late for dinner. He dined an hour and a half after his usual time, entertained a party of friends with his customary cheerfulness and vivacity, and went late to bed. On lying down he uttered a slight groan, was found unconscious and to be in a state of general tremor, and almost instantly died.

In January, 1895, the speaker was consulted by a gentleman, aged 84, on account of severe anginoid attacks, the pain radiating from the cardiac region to the spine and down the left arm. They frequently came on when he was in bed, especially if he tried to apply ointment to eczema, from which he was suffering, while in the recumbent position, and they were induced by slight exertion. The pulse intermitted about once in eight beats, was large and short, and the walls of the vessel were thin. The heart was about normal in size, a slight impulse was recognizable, the first sound was short, and a rough systolic aortic murmur was present. The bowels were much constipated and the stomach distended. There was, no doubt, some degeneration of the heart, but it seemed probable that the attacks were provoked by pressure from the distended colon and stomach. This was especially suggested by the fact that the attempt to reach the lower part of the body to apply this ointment when in the recumbent position was certain to bring on the pain.

He was relieved by treatment based on this view and was seen only at long intervals; in July and November, 1895; then not till July, 1896. In the meantime he played whist at his club three or four hours a day, went to the city occasionally, and walked short distances. When last seen, on July 31st, he spoke of the angina as having returned after a prolonged absence, together with giddiness on rising from bed or stooping; the distension of the stomach was enormous. He was found dead in bed a few days later. Here, no doubt, the heart was nearly worn out; but none the less the last straw was the distension of the stomach.

Another patient, a hard-working solicitor, aged 69, of eager temperament, had a narrow escape this year. He had consulted the speaker at long intervals for the effects of overwork and indigestion, and had had for some years a weak, irregular pulse, which had been worse since an attack of influenza some two years before. One morning in May he was brought to the speaker by his wife after a series of five city dinners. He ridiculed his wife's fears and said there was nothing the matter with him; but the distension of the stomach was so great and the effects on the heart so serious that Dr. Broadbent forbade him to go to his office and told him to return home at once. He obeyed him so far as not to go to business, but instead of going home he went shopping, and while looking at some article he turned deadly white, his jaw fell, and he became unconscious. He was brought around by brandy, but the stasis of the circulation lasted long enough to allow of thrombosis of a small vessel in the speech-centre.

Persistent dilatation of the stomach with occasional attacks of distension may wear out a really strong heart.

Some years ago the observer had been consulted by a lady, aged about 62, on account of attacks which had been called angina. The pain was very severe, and radiated down the left arm; the attacks did not come on during exertion, but in repose, and especially at night; they lasted too long, also, for true angina, and were in no way characteristic. From the symptoms alone it was evident that the case was one of pseudangina of gastric origin. This was confirmed on examination. The pulse was large, tense, and well sustained; the heart somewhat enlarged, with the powerful thrusting apex-beat and impulse of hypertrophy. The bowels were constipated and the stomach considerably dilated. The spurious angina ceased at once under treatment by mild aperients and an alkaline tonic and carminative mixture with regulated diet; but the patient would not submit to have the stomach washed out. She took no exercise, fed injudiciously, and after an immunity of many months the attacks returned. In the course of years he saw her with different medical men, and other physicians were consulted. Digitalis and strophanthus were given at different times when the patient was not under his observation, but, so far as he could learn, with disastrous results. Early in the present year the attacks became more frequent and severe, and under their influence the tension of the pulse was reduced and the action of the heart became less vigorous, the apex-beat, however, being well defined and thrusting, till at length acute dilatation of the heart took place during an attack, the apex-beat becoming diffused and displaced to the left and entirely losing its thrusting character. The next attack proved fatal.

Diagnosis of Dilatation of the Stomach.—The diagnosis of dilatation of the stomach is usually very easy, especially when there is also the distension which renders it dangerous, but it must be remembered that the height and extent and character of the tympanitic resonance, and the distinctness and volume of the splash, will vary greatly, according to the time after food at which the examination is made and the character of the last meal. The stomach may at a given moment be empty and collapsed, especially in cases attended with diarrhœa. Only three weeks before he had been consulted by Dr. Brown, of Wateringbury, on a case of long-standing diarrhœa, in which, from the character and copiousness of the motions, he concluded that they came from the upper part of the small intestine, and from the history and duration that there was probably some lesion which was not amenable to medical treatment. The abdomen was hollow, and to the left of the median line just above the umbilicus there was a point of resistance and tenderness. He considered that an exploration was desirable, and that, at any rate, a surgeon should be consulted. The case was submitted by Dr. Brown to Mr. Treves, who opened the abdomen, and this is his report: "The stomach was so dilated that it filled literally nearly one-half of the abdomen. It extended into the left iliac fossa, and in the median line it reached to within an inch and a half of the pubes. The seat of tenderness on the left side corresponded to the much-displaced pylorus, which was occupied by a firm, fibrous ring." This Mr. Treves divided and dilated.

The point of the case in relation to the present subject is that at the time of his examination this enormous stomach must have been empty and collapsed; there was none of the resonance which it would have given if it had contained gas, and the epigastrium was depressed. The facts of this case tend to confirm a conjecture he had made before, that in certain examples of dilated stomach the anatomical disposition of the pylorus is such that the weight of the viscus when laden with a heavy meal makes the flexure at the junction of the stomach and duodenum so acute as to prevent the ready exit of the gastric contents. In the horizontal position the dragging is relieved, the obstacle at the pylorus is removed, and the small intestine may be flooded with chyme.

Etiology and Treatment of Dilatation of the Stomach.—It must not be supposed that the sole cause of dilatation of the stomach is error of diet, or that it can always be cured by regulation of the food. It is very common as an incident, so to speak, of the neurotic condition, and more than once, when a dilated stomach in such cases has been washed out, it has been found that digestion has proceeded with remarkable rapidity and efficiency. The dilatation may be due entirely to atony of the muscular walls, allowing of passive distension of the viscus, and not to any distending influence from within by superabundant evolution of gases; and sleeplessness from worry or grief is not infrequently brought about indirectly, the depressing emotions giving rise to dyspepsia and loss of tone in the muscular coats of the stomach, and the consequent dilatation of the stomach giving rise to the loss of sleep. In the treatment of this affection, therefore, while it is necessary, in the first instance, to neutralize the acids and promote the expulsion of the gases resulting from fermentation and to destroy the fermentative organisms or, at least, arrest their activity, the condition of the nervous system must receive attention at the same time and at a later stage.

The Relations Between Anæmia and Phthisis.—Every year the speaker sees scores of anæmic and chlorotic girls, with or without amenorrhœa, some of whom look as if they were already victims of phthisis, and all of them seeming, from their weakness and pallor, to invite its onset; but he scarcely ever meets with them later actually suffering from phthisis. Perhaps they are taken to other physicians if attacked by this disease; but he does see a certain number of them afterward. The question now is whether his personal experience corresponds with that of men in general practice, who watch these girls grow up to womanhood. If this is so, then anæmics enjoy some sort of immunity from phthisis, and anæmia is protective in a certain degree against tuberculosis. Possibly this might be capable of practical application.

The whole subject of immunity from and proclivity to disease produced by micro-organisms is being eagerly investigated and is full of interest. The relations of these diseases to each other are worthy of study, and when explained by experiment will constitute an important chapter in medical science. Some of them predispose to others,—measles to whooping-cough, influenza to typhoid fever. This last again predisposes to tuberculosis. Typhus, on the other hand, did very frequently, in the gigantic epidemic which occurred in the early period of his work as physician to the London Fever Hospital, leave the patient in better health than before the attack; possibly because of the good feeding during convalescence; but, reflecting on the fact since, it has seemed to him that the bacillus of this disease, or its toxin or antitoxin, might perhaps clear the system of all other pathogenic bacteria. There is evidence, pointing in the direction that an attack of one form of disease may destroy the microbes of another, in the fact that a severe attack of small pox may completely arrest phthisis. Some remarkable cases illustrating this were published a few years ago, among others by Dr. Lawrence, of Chepstow.

Nervous Anorexia.—In this disease there is an extraordinary disinclination for food and very little is taken; the emaciation is extreme and yet the patient seems capable of and will take any amount of walking exercise. According to the speaker's experience, only young girls suffer from this disease; and, whereas in anæmia and chlorosis amenorrhœa is secondary to the deterioration of the blood, it is here primary and forms the starting-point of the symptoms. Have we not in this affection another illustration of reaction between a given organ and the system generally? Is it not a consequence of the suspension of ovarian activity and of the absence of some substance normally returned by the ovaries to the blood? Perhaps ovarian extract may be of service in such cases; he thinks he has seen good effects, but his experience as yet is small.

The Treatment of Epilepsy.—He had previously expressed the opinion, and does so again, that it has been too much the rule to give bromides in epilepsy, as it has to give digitalis in heart disease. The results are often disastrous. If the attacks are arrested, which is very rarely the case, the patient may be a nervous wreck. "*Il est mort guéri*," said the enthusiastic dermatologist when the skin of his dead patient was free from the eruption he had been treating. Some of these "cured" epileptics are worse than dead.

In all forms of epilepsy there are two elements—the inherent tendency in the nervous system to convulsions, which may be interpreted as instability of the nerve-cells of the higher centres, and some influence outside the nerve-centres—which determine the attack. In true epilepsy, by which he means cases in which the paroxysms have begun to appear during adolescence, the inherent tendency is the predominant factor, and very slight exciting causes suffice to precipitate an attack; but, when there has been no development of the disease between puberty and adult age, it may be looked upon as certain that some disturbing influence plays an important part in the causation of the attacks. He had seen a dead terminal phalanx, killed by an attack of whitlow, give rise to very severe epilepsy, which at once ceased when the bone was removed. So also a piece of glass imbedded in the wrist near the ulner nerve. But crowds of such cases are recorded. Intestinal worms, again, have undoubtedly given rise to epilepsy, and ovarian irritation is a recognized cause of a certain form of the disease. Whenever, then, epileptic attacks make their appearance in adult life, a persevering endeavor should be made to discover some functional derangement which may have upset the equilibrium of the nerve-centres. In his experience, dyspepsia, especially associated with dilatation of the stomach, has given rise to recurrent epileptiform attacks, which have ceased with the removal of the disorder of the digestion.

A lesson may also be drawn from the epilepsy of early syphilis at a period of the disease when gummatous exudation into the meninges of the brain does not take place and no coarse lesion is found after death. If the constitutional disturbance attending early secondary syphilis can cause epilepsy, it is possible that other remedial constitutional conditions may occasionally have this power.

But even in true epilepsy, in which there is inherent instability of the cortical centres, much may be done to reduce the frequency and severity of the attacks without deadening the nervous energies by bromides. Apart from a tendency to periodicity not easily explained, one of the most common exciting causes is variation of the general blood-pressure and languor of the cerebral circulation. The convulsions are most frequent in the night, when the circulation has run down during sleep, or in the early morning when the blood is not carried vigorously to the head,—witness the purple face of some weakly person in the early part of the day. They scarcely ever occur during exertion or during febrile conditions. Now, these fluctuations of the circulation can be minimized by measures which raise the tone and increase the vigor of the heart and vessels,—early hours, fresh air and exercise, regular and simple meals, aided, if necessary, by tonics. For many years he has been accustomed to distinguish between high-tension epileptics and low-tension epileptics, according to the state of the pulse. The prognosis is much more favorable when the arterial tension is high, since it is easier to reduce the resistance in the arterioles and capillaries and lower the tension by eliminants and non-nitrogenous food than to give new vigor to the heart and fresh tone to the vessels.

Our endeavors need not end even here. It is not impossible to diminish the instability of the nerve-cells by improving their nutrition. Unless he has deceived himself, this has not infrequently been attained by the administration of phosphorus and strychnine. At any rate, durable recoveries have taken place under this treatment.—*Birmingham Medical Review*, November, 1896.

UNITED STATES.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

The Relation of Anæmia to Chorea.—DR. C. W. BURR, of Philadelphia, gave the results of a study of the blood of 36 cases of Sydenham's chorea, the examination having been conducted by DR. JAMES E. TALLEY. In each case the hæmoglobin was estimated and the red corpuscles counted. No account was made of the white corpuscles. The hæmoglobin and corpuscles were at the theoretical normal in only 2 cases. In none was the anæmia extreme. In the most severe case the hæmoglobin estimation was 45 per cent. and the number of red corpuscles 3,450,000. The chorea was slight and the patient had serious heart disease, to which the anæmia was referred. In another case, complicated by epilepsy, the hæmoglobin estimation was 60 per cent. and the number of red corpuscles 3,600,000. In 1 very bad, uncomplicated case the hæmoglobin estimation was 65 per cent. and the number of red corpuscles 4,800,000, and in another the hæmoglobin estimation was 60 per cent. and the number of red corpuscles 3,850,000. These were the most anæmic cases. In 24 the hæmoglobin estimation reached 80 per cent. or over and the number of corpuscles 4,000,000 or more. In 29 the hæmoglobin estimation reached 75 per cent. or over.

The conclusion was reached that the blood is rarely absolutely normal during an attack of chorea. There is usually a moderate diminution in the hæmoglobin and a relatively still smaller decrease in the number of red corpuscles. The anæmia is, therefore, chlorotic in type. There is no relation between the severity of the chorea and the severity of the anæmia. When the anæmia is severe there is usually some complication competent to explain it. The belief was expressed that anæmia is not an immediate, direct, exciting cause of chorea, and but infrequently a predisposing cause. In the great mass of choreas the anæmia is the result of the chorea,—is secondary. In the rare cases of chorea which seem to be caused by mycotic infection the anæmia may be toxic.

DR. WHARTON SINKLER stated that the impression prevails among the medical profession at large that anæmia is a predisposing cause of chorea.

The Collective Investigation Committee of the British Medical Association a few years ago collected 432 cases of chorea and found that 92 of these were anæmic. Dr. Rachford, of Cincinnati, considers that chorea is due to what he calls a scrofulous anæmia, and says that it is directly curable by iodide of iron.

In Philadelphia, or at least among the patients who come to the Infirmary for Nervous Diseases, choreic children, as a rule, do not look anæmic. A scrutiny of the books at the infirmary shows that of 46 cases in which a blood-count was made—probably including those studied by Dr. Burr—the average number of corpuscles was 4,825,000 to the cubic millimetre; that in 7 cases the number of corpuscles amounted to 6,000,000 and over; in 10 between 5,000,000 and 6,000,000; and in 16 between 4,500,000 and 5,000,000. The hæmoglobin estimates were practically normal,—that is, out of 47 cases in which an examination was made as to the percentage of hæmoglobin there was an average of 79.4 per cent. The lowest blood-count was 2,800,000, the highest 6,500,000. In 12 cases the hæmoglobin was estimated at over 90 per cent. These results are about as good as would be expected in an equal number of healthy children. They bear out the assertion that anæmia does not predispose to chorea.

Dr. Alfred Stengel said that in the blood in about half a dozen cases examined by him the average blood-count was between 4,000.000 and 5,000,000, the hæmoglobin being about equally reduced. In no case was there marked anæmia. In a few cases there was a moderate leucocytosis. Altogether, the conclusion seems justified that anæmia is not a frequent complication of chorea, much less a cause of the disease.

The interesting fact, however, to be considered is that many cases of chorea present an anæmic appearance. This has led to the general belief that chorea is associated with anæmia and is probably dependent upon it. An anæmic appearance, however, is by no means always an indication of actual anæmia. In a recent paper on chlorosis, by Dr. Townsend, of Boston, allusion is made to the unreliability of pallor of the skin or mucous membranes as a sign of reduction of hæmoglobin. The reverse is also true. Individuals who have normal blood may present an exceedingly anæmic appearance.

A few years ago a form of disease was described by Winternitz, of Vienna, as anæmia spuria acutissima. A female servant, who, in trying to mount a ladder, fell, suffered a severe nervous shock, and at once became extremely pallid. The pallor persisted, but on examination the blood was found entirely normal. This condition was believed to be due to disturbance of the vasomotor system. Perhaps the same principle may apply to chorea and other nervous diseases.

The possibility of there being quantitative anæmia in chorea is, of course, a new theory, as there is no way by which the presence of quantitative anæmia during life, or even after death, can be reliably determined. However, all the associated conditions and the experimental evidence point to the fact that quantitative anæmia, if it ever exists, is very rare. There may sometimes be such a thing in progressive pernicious anæmia. Dr.

Stengel alluded to a case in which there was an extremely anæmic and desiccated condition of the organs, in which the blood-vessels throughout the entire system were empty of blood, and in which the blood-count had been very low. Such cases are possibly instances of quantitative anæmia, but in chorea the appearances are never of this character. There is not the same difficulty of obtaining blood from the finger; not the shriveled or shrunken condition of the tissues; not the apparent failure of the peripheral circulation present in cases displaying the external appearances of what would be expected of a quantitative anæmia.

It is believed, therefore, that in cases of chorea there is only that amount of anæmia which comes from some toxic or some general nervous disturbance. Chorea may be looked upon as a toxic condition, probably an infectious toxæmia, and the existence of a moderate leucocytosis, as found in some cases, may or may not be taken as of some significance in this connection. Apart from the actual anæmia, the spurious anæmia or pseudo-anæmia so often met with must not be ignored, and this for want of a better explanation may be ascribed to vasomotor conditions. As many of the blood examinations in cases of chorea are made in out-door clinics, and most of the patients are young persons, the examinations are in themselves unreliable to some extent.. They are fallacious from the defects of the instruments used; and, furthermore, the excitation of the heart and of the circulation, consequent upon coming to the clinic, causes a peripheral corpuscular congestion (if such a term may be used) from the more vigorous action of the heart in driving blood into the periphery; or there may be the reverse condition, due to cold contraction of blood-vessels, which raise the blood-count by causing venous congestion. Therefore there is probably a higher degree of anæmia than appears in the examination; but decided anæmia is unquestionably very infrequent in chorea.

Dr. James Tyson said that the entire compatibility of pallor with a normal composition of the blood is evident when we think of the pallor that attends the syncopal attack, which furnishes, for a short time, all the external phenomena of anæmia. It would be an interesting matter to determine the condition of the heart in these cases in which there is an appearance of anæmia in association with chorea while the actual blood-count and hæmoglobin measurement fail to disclose the essential conditions of anæmia. We have only to consider a permanence of the conditions that prevail during a fainting fit—of course, in milder degree than in an actual faint—and we have those of a chorea and yet a normal composition of the blood.

Dr. Wharton Sinkler asked for an expression of opinion from those who have had experience in the matter of blood-counting and estimation of hæmoglobin as to how much the results of examinations depend on the individual.

Dr. Alfred Stengel said that he had made no study of the errors in blood-counting, but in a recent paper by Moyer (*Deutsches Archiv für klinische Medicin*, Bd. lxvi) upon the errors of the hæmometer of Fleischl variation in results were attributed to fatigue, the personal equation, and the skill of the experimenter, as well as to defects in the instrument itself.

In examinations made simultaneously by Dr. Stengel and a colleague some years ago with the Fleischl instrument a difference of 10 per cent. was sometimes found. Gradually with increasing experience the error decreased.—*Philadelphia Polyclinic*, November 7, 1896.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Italia.

PROF. F. MASSEI,
REDATTORE CORRISPONDENTE PER
LE LARINGOLOGIA E
RINOLOGIA.

Si prega di mandare tutti i giornali, libri, stampe, etc., sulle suggetti sopra nominate che vedono la luce in Italia al

PROF. F. MASSEI,
4, Piazza Municipio,
Napoli.

Otitic Thrombosis of the Transverse Sinus.—GRADENIGO (*Arch. ital. di otol.*, etc., vol. iii, No. 4, 1895) considers the operative procedure for intracranial complications of purulent otitis of the middle ear as pretty clearly established, but states that the diagnosis of the affection is yet faulty as regards certainty and precision. Among the complications of otitis, septic or non-septic thromboses of the transverse sinus rank second as to frequency after extradural abscess. In sixty-eight cases of acute or chronic mastoiditis operated by the author during the year there were five cerebral or cerebellar abscesses. He gives an account of three cases of thrombosis of the transverse sinus.

Hysterical Aphonia and Deafness.—TRIFILETTI (*Arch. ital. di otol.*, etc., No. 3, July, 1895) gives an account of a case in a female servant, 18 years old, of good constitution, who had always been in good health and has never had any nervous troubles, the same being the case with the other members of her family. Since some time her menstruation had been irregular, scanty, and accompanied by pain in the left ovarian region and the back, as well as by frontal cephalalgia. The aphonia dated back fifteen days, and began at the period of menstruation, following an emotional shock. The patient presented herself at the dispensary, where a laryngoscopical examination was made; this disclosed bilateral symmetrical paralysis of the adductors of the vocal cords, which in no way corresponded with the degree of aphonia, and was probably referable to hysteria. Chronic rhinitis with secondary pharyngitis and hypertrophy of the tonsils were noted. After some agreeable surprise the voice returned, but at the same time the hearing was abolished. The patient also complained of buzzing in the left ear, and of a sense of weight at the top of the head, the back, and the left ovarian region. Deafness was not complete and presented the clinical characteristics of hysterical deafness. Otoscopy showed nothing abnormal with the exception of a slight opacity and retraction of the two membranes of the tympanum. Afterward the aphonia appeared, subject to variations, disappearing spontaneously and reappearing upon compression exerted upon the ovarian region. The hearing became spontaneously and permanently normal.

The author concludes that the symptoms in this case were due rather to an impressionable sensorial hemianæsthesia than to peripheral hysteria, since the manifestations were diffuse and mainly located on the left side.

Recurrent Laryngeal Papillomata.—MASSEI presented before the Naples Academy of Medicine a girl, who, notwithstanding thyrotomy performed for diffuse papillomata of the larynx, did not recover her voice, while recurrence took place on the lower surface of the left vocal cord. Massei emphasizes the opinion, already expressed, that, when, for laryngeal papillomata, it is impossible to operate by the endolaryngeal method on account of dyspnœa, simple tracheotomy may be sufficient, not only because there are well-authenticated cases of spontaneous disappearance of the growth, but also because thyrotomy (as in the case presented) may prove insufficient for a complete treatment.—*Archivii Italiani di Laringologia*, vol. xvi, No. 2, 1896.

Caseous Rhinitis.—In a clinical lecture on a case of caseous rhinitis treated and cured by MASSEI he resumes as follows the symptoms and different opinions: He admits that caseous coryza may be dependent upon various causes, but he states that the special nature of the morbid condition justifies the autonomy accorded to it by the various authors. He considers the name "caseous" more correct than that of "cholesteatomatous," and, having confided the bacteriological researches to one of his assistants,—Dr. Guarnaccia,—he states that the micro-organism which Sabrazès considered as a filamentous bacterium is, on the contrary, the streptothrix album, already isolated, cultivated, and controlled by Professor di Giaxa, of Naples. While studies and experiments are still in progress, Massei believes that three elements are necessary for the production of caseous rhinitis: (1) an abundant purulent secretion in the nose, (2) an obstacle to its discharge, and (3) the presence of the streptothrix album, which finds a favorable field for its germination. Further statements from Guarnaccia are promised.—*Archivii Italiani di Laringologia*, vol. xvi, No. 2, 1896.

Action of the Rœntgen Rays upon the Bacillus of Diphtheria.—BERTON exposed bouillon cultures of the above bacillus to the Rœntgen rays during sixteen, thirty-two, and sixty-four hours. After each of these periods the cultures were sown in bouillon and injected in guinea-pigs (two guinea-pigs for each culture). A control culture was also resown and injected into two guinea-pigs. No results were obtained. The cultures exposed and resown grew as rapidly and abundantly as the control cultures, and the animals died as quickly as those also used as controls. (*Bull. Gén. de Thérapeutique*, November 8, 1896.)

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM
FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

Castration in Hypertrophy of the Prostate Gland.—G. EKEHORN (*Hygiea*, vol. lviii, No. 8, pp. 148 to 153) reports several cases, as follows:—

Case I.—Seventy years old. Symptoms of hypertrophy of the prostate for many years; since half a year cystitis, which had resisted treatment during two months in the hospital. Double-sided castration, with perfect recovery.

Case II.—Sixty-eight years of age, having hypertrophy of the prostate, with cystitis. Subsequent improvement. Since several years, strangury; finally complete retention, with cystitis. Prostate somewhat enlarged, mainly from side to side, the lateral lobes being very hard. Owing to a change for the worse in the catarrh of the bladder and the impossibility of spontaneous urination, Ekehorn performed a double-sided castration, with recovery. Sixteen days after the operation the patient began to pass urine spontaneously, beginning with a small quantity daily. On his discharge from the hospital the residual urine amounted to about 125 grammes.

Case III.—Sixty-two years old. Hypertrophy of the prostate, with comparatively slight symptoms. Complete retention. About 500 grammes of residual urine. Bilateral castration, with normal recovery. Residual urine, 75 grammes. No noteworthy reduction of the prostate.

Case IV.—Seventy-three years of age. Hypertrophy and cystitis. The enlargement of the solid and hard prostate was not very considerable; its superior border easily palpable. The enlargement was chiefly on the sides, especially on the right. Arteriosclerosis. Bilateral castration, with normal recovery. Spontaneous partial evacuation of urine,—about 500 grammes in 24 hours. The nearly constant use of the catheter was not benefited by the operation. Residual urine, 500 grammes.

Statistics Relating to the Occurrence and Significance of Lactic-Acid Fermentation in Cancer of the Stomach.—G. EKEHORN states that, in 81 cases of carcinoma of the stomach examined for lactic acid, the latter was found in the contents of the stomach in 25. In 22 of these cases the diagnosis of cancer was undeniably verified and in 2 others it was very probable. Only in 3 cases of cancer was lactic acid totally absent. The demonstration of the formation of lactic acid has great practical significance in those cases in which the diagnosis may otherwise be dubious, and particularly in the cases in which this symptom can be proven in an early stage of the malady. Extirpation of the gastric cancer (resection of the pylorus, with favorable result) was only performed in one single case. The surgical material is yet too small to enable us to estimate how often the lactic-acid fermentation occurs in the contents of the stomach, at a comparatively early stage of gastric cancer, and what real value this symptom may possess with regard to the curing of the disease. Owing to the very rare occurrence of lactic-acid fermentation in other diseases of the stomach than cancer, one is justified in making an explorative laparotomy in the cases where there is constant occurrence of lactic acid, previous to eventual extirpation.—*Upsala läkareförenings förhandlingar*, new series, vol. i, No. 8, pp. 496 to 518.

On the Perception of Simultaneously Continued Irritation by Cold and Heat, Localized at One and the Same Place.—FORSTEN THUNBERG has made experiments with an apparatus consisting of two brass tubes, each of which forms a spiral of two and one-half turns, and covering a circular surface 5.5 centimetres in diameter. The external diameter of the brass pipe made use of to form the spiral is about 3 millimetres, and, when one spiral is symmetrically fitted into the interstices of the other, the two are separated by an intermediate space of 1 millimetre. In order to be able to curve the brass pipe to the form required, it is filled up with lead, and after it is bent the lead is melted off. The question as to whether one can really obtain a simultaneous sensation of cold and heat from the same point on the skin, the author answers decidedly in the affirmative, thus differing from Goldscheider. If over a physiological spot showing +34° C. (93.3° F.) water at +44° C. (111 5° F.) is conveyed through one pipe and water at +24° C. (75° F.) through the other pipe, the apparatus first excites a sensation of cold, which soon intermixes with the subsequent perception of heat. In the mixed sensations arising at that moment the impressions of cold and heat are coalesced into a peculiar heat-perception. The sensations of cold and heat do not, however, always intermingle in this way.—*Upsala läkareförenings förhandlingar*, new series, vol. i, No. 8, pp. 489 to 495.

Case of Otitic Pyæmia.—CHARLES DAHLGREN reports a case of otitic pyæmia, with operation and recovery. Maid-servant 16 years of age. Symptoms of a very severe, general infection of pyæmic nature. The sole reasonable cause was an otitis media chronica, the consequence of a diphtheria experienced four years before and now manifesting itself by otorrhœa, slight pains, and tinnitus. No signs of propagation of the infection to the air-cells nor to the bone in the mastoid process. No intumescence, sensibility, or redness in the mastoidal region. Under these circumstances Dahlgren considered the upper part of the vena jugularis interna as the door of entrance for the general infection, all the more so as the upper part of the sheath of the vessels was sensitive. The diagnosis before the operation was that of otitic pyæmia, with a thrombophlebitis in the upper part of the vena jugularis interna as interagent. But at the operation there appeared severe alterations in the processus mastoideus, notwithstanding the absence of symptoms; that is to say, the mastoidal antrum was filled up with pus and its posterior wall destroyed; so that the pus had penetrated into the fossa cranii post., where it had reached the transverse sinus. Ligation of the vena jugularis. The transverse sinus was left unopened, because the abundant hæmorrhage from the mastoidal emissarium showed that no obturating thrombus was present. Essential subjective and objective amelioration with lowering of the temperature, which was, at most, normal during the first six days. Thereupon considerable impairment with recrudescence of the pyæmic processus in consequence of dissemination of infectious germs through the vena jugul. int. sin. Yet the fossa cranii media was free, and the thrombus was macroscopically not fallen to pieces, but the subsequent suppuration within the vena jugularis int. sin. showed that the thrombus concealed infectious substances. The result of an exploratory puncture of the cerebellum was negative. The tumefaction of the entire face, which set in after two days, hinted at a thrombosis of the cavenous sinus, the rather as its repeated appearance coincided with manifest fall of the thermometer, and not as in erysipelas with rise of the temperature. —*Upsala läkareförenings förhandlingar*, new series, vol. i, No. 8, pp. 439 to 444.

On the Inversion of the Uterus.—The principles for the treatment of the disease in question C. D. JOSEPHSON summarizes as follows:—

1. Acute puerperal inversion must be reduced with all speed by means of prompt and energetic measures.

2. If the reduction does not succeed, in profuse metrorrhagia, a coil is applied all around the neck of the inversion. After some hours the brace is unwound and further trials for reducing the inversion are made. If the hæmorrhage is insignificant, no constriction, but tamponing.

3. During the first days of the puerperium cautious attempts for reducing during narcosis. Thereupon involution must be awaited, while constantly endeavoring to reduce by means of the colpeurynter, combined with tamponing with gauze of iodoform. Even in very old inversions energetic attempts should be made with the colpeurynter.

4. If these miscarry, Küstner's method should be attempted; if even that does not succeed, amputation or, rather, total extirpation of the uterus is executed.

Case I (PROFESSOR MAURITZ SALIN).—Married; aged 27 years. After the second, normal delivery the physician, called in on account of profuse metrorrhagias, caused inversion and prolapsus of the uterus underneath the vulva by means of pressure on the womb and tractions upon the navel-string. Expectation. The metrorrhagias became frequent and more and more profuse. Since neither colpeuryses nor repeated trials of reduction led to the desired result and Küstner's method was of no avail, the uterus was extirpated in its entirety. The patient recovered.

Case II (DOCENT C. D. JOSEPHSON).—Married; aged 42 years. After the first, only delivery seventeen years ago the secundines were torn out by the midwife on account of metrorrhagia, which was soon stilled. During medication with iron preparations the percentage of hæmoglobin in the blood amounted only to from 20 to 25, but while taking arsenic reached 60. At the operation the author successively severed the posterior uterine wall from the external orifice of the womb all the way down to the fundus; but notwithstanding this it was impossible to reduce the inverted uterus, although he tried to perform reinversion while griping the edges of the cut uterine neck with sharp-toothed forceps. He then extirpated the entire uterus and sutured the incision, leaving a little opening, into which he introduced a strip of iodoform gauze. Ovaries and Fallopian ducts were left intact. The patient recovered.—*Hygiea*, vol. lviii, No. 7, pp. 55 to 80.

Clinical Notes and Lectures.

Heart Disease and Marriage.—Peter, of Paris, used to say that no woman suffering from any disease of the heart should, if unmarried, marry; if married, have children; and if with child, be allowed to go to full term.

In a clinical lecture delivered at the Pitié Hospital PROFESSOR JACCOUD criticises this statement as too absolute. He thought that under some conditions a physician consulted as to the advisability of the marriage of a female patient might consent. In the first place, opposition to the wishes of the patient might in itself be most unfavorable. Then, too, it should be ascertained whether the cardiac lesion had already produced any such symptoms as dyspnœa or hæmoptysis. Even in this latter case it would be well not to be too severe when it was shown that such occurrences had been rapidly ameliorated by suitable treatment, and when the social position of the patient would allow a proper hygiene.

What, however, Professor Jaccoud especially recommends, is that the patient should be placed upon a partial milk diet from the second or third month of pregnancy, 2 litres (quarts) of milk being taken daily. This tends to prevent not only the cardiac symptoms already mentioned, but also the presence of albumin in the urine.

Professor Jaccoud declares that he authorizes marriage in cases which have not previously shown any very serious symptoms, on condition that such a regime be followed during pregnancy.—A. R. TURNER, in *The Therapeutic Gazette* of October 15, 1896.

Toxic Effects of Strong Coffee.—J. T. RUGH, relates a case in which profound toxic effects from the drinking of large quantities of strong coffee were observed, a number of symptoms being those of beginning *mania à potu.* The patient's pulse was 96 and full, but weak; his respirations shallow and numbering 24 to the minute. The pupils were normal, the tongue slightly coated, the bowels regular; the skin moist, but not flushed; and his expression was agitated with the fear of some impending danger. His muscles were in such a state of tension that upon the slightest movement of arms or legs clonic spasms occurred, though none was present when he lay perfectly relaxed, which, however, his exceedingly nervous condition would not allow him to do. If he tried to sleep, he would be seized with hallucinations just before losing consciousness, imagining that disasters were about to overtake him and seeing all kinds and shapes of images and objects. Then he would start up with fright and find himself in the greatest nervous excitement. When he stood up, he could close his eyes or look at the ceiling without wavering. His knee-jerks were slightly exaggerated, but sensation was perfect.

The diagnosis of coffee intoxication was based upon the history of excessive coffee-drinking for three weeks, the absence of liquor-drinking in quantities sufficient to produce constitutional effects, the nervous symptoms (spasms of muscles, hallucinations, and extreme excitability), and the absence of an attack simulating petit mal in any way.—*Medical and Surgical Reporter*, October 31, 1896.

Morphine-Ether Narcosis.—Riedel (*Berl. klin. Woch.*, September 28, 1896), alluding to the fact that there are more sequelæ (such as bronchitis, etc.) after ether than after chloroform narcosis, states that in the former cardiac paralysis and sudden arrest of the respiration do not occur. To guard against the danger of bronchitis, the sensibility of the bronchial mucous membrane should be diminished in order to lessen secretion. For this purpose the author gives an injection of morphine before the administration of ether. He has come to use this method more and more widely. Before the fourteenth year, however, the morphine is omitted. From 13 to 18 years of age 0.005 gramme ($\frac{1}{12}$ grain) is given, and to older persons 0.01 gramme ($\frac{1}{6}$ grain). This amount may not be sufficient in drunkards. Half an hour after the injection the ether is administered cautiously, only 3 or 4 grammes (45 to 60 grains) being poured on the inner side of Julliard's mask. The mask is not pressed on the face at once; so that time is allowed for the patient to get used to the ether, and thus there is no tendency to cough. The mask has a cover of oiled paper, and a few drops of ether are from time to time poured through the opening in it. If the operation only takes an hour the effects of the morphine will last, and very little ether is necessary, but in longer operations much more ether may be required. Sleep is prolonged after the operation for a considerable time. The author has never observed bronchitis in children after ether. He has employed this method of anæsthesia for operation on all parts of the body during the past three years. If it were not for bronchitis ether would be an ideal anæsthetic. Even fifty years after the discovery of chloroform a safer anæsthetic than chloroform is wanted. At present he observes that we must be satisfied with ether, which he looks upon as the best available anæsthetic. In only one case was death directly attributable to the ether, and the patient was here the subject of emphysema. There have been isolated cases of pneumonia, mostly in elderly and cachectic persons, and not to be put down to the ether. Ether exercises an irritant action upon the bronchi, and Riedel believes that the greater part of its dangerous properties may be avoided by the above-described mode of administration.—*British Medical Journal*, November 14, 1896.

Chloroform Anæsthesia During Sleep.—In order to operate on an obstreperous child 3 years of age, Israel Cleaver, of Reading, Pa., administered chloroform while the latter was asleep. The patient's pulse and respiration showed the usual changes of progressive narcosis, but without any apparent disturbance of sleep. When the conjunctival reflex seemed abolished, an attempt was made to open the mouth, but resistance and some movement of the limbs were manifest. With a very little more chloroform, complete relaxation ensued, and the frænum was satisfactorily exposed and snipped. Normal sleep seemed to follow, the pupils being contracted. The child recovered normally.—*Medical and Surgical Reporter*, October 31, 1896.

Proper Diet in the Pneumonia of Children.—An editorial writer in the *Therapeutic Gazette* of October 15, 1896, in an article on the treatment of pneumonia in children, emphasizes the absolute necessity of maintaining from the beginning to the end of the attack a definite plan by which nourishment in an easily-digested form is provided for the child. More depends upon the maintenance of its strength, and therefore upon the preservation of its digestion, than many physicians seem to think ; and, in addition to leaving written orders for the nurse as to the manner in which medicines are to be employed, the physician should give careful directions as to the means by which the food is to be prepared and the frequency and quantity in which it is to be administered. Care should always be taken to keep the kidneys acting freely by the use of some simple pure diuretic water, to which may be added several times a day a few drops of sweet spirit of nitre.

Surgical Treatment of Renal Calculus.—NASH reports four interesting instances of renal surgery. The first was a case of hydronephrosis, depending upon the presence of a calculus which, when aggregated in the renal pelvis, had failed to pass along the ureter, and, by occasionally blocking the waterway, led to serious distension of the inclosing structure and the formation of a fluid tumor, which occupied at one time the lumbar region and at others passed up under the liver and ribs, to be hidden both from sight and touch. Through a vertical incision two and one-half inches from the centre of the lumbar spines the kidney was speedily reached, the pelvis defined and incised, and the calculus removed. The patient, a woman aged 38 years, made a good recovery. In the second case there was a persistent tumor in the loin, which did not appear to vary much in size. This was found to be due to closure of one of the papillæ by flakes of phosphate of lime, and consequent distension of the corresponding calyx. Incision of the kidney, followed by dilatation, resulted in the discharge of several ounces of white, flaky material. Careful examination of the cavity failed to reveal any solid, calculous mass. This operation was completely successful, and on the fourth day the urine ceased to flow by the lumbar wound. The third patient, a woman aged 54 years, had a suppurative pyelitis and a perinephritic abscess of large extent, the communication between the former and the latter being a small opening in the renal pelvis, or, more correctly, one of the calyces of this cavity. Under this lay a small, phosphatic calculus imbedded in a mass of soft granulation tissue. The large purulent cavity was opened by an oblique incision parallel to the last rib and the calculus removed. The patient, who at the time of the operation was in a very critical condition, was well and able to leave the hospital at the end of the sixth week. In the fourth case, which was one of severe lumbar pain on the right side and hæmaturia, a brown, almost circular stone was found lying in one of the posterior calyces. The renal structure and both the fibrous and fatty capsules of the organ were in a normal condition.—*British Medical Journal*, November 14, 1896.

Cure of Inguinal and Crural Hernia by Tendinous Autoplasty.—POULLET performed a genuine deep-seated tendinous autoplasty, using a portion of one of the tendons of the thigh. This tendon is separated below from its muscular insertions and remains adherent to its upper, osseous insertion. A long portion of the crural triceps is used in inguinal hernia, and the first adductor or long portion in crural hernia. The peritoneum is not opened. Two incisions are made: one parallel to the arcade, to reach the sac; the other vertical, upon the course of the right anterior muscle of the thigh, to dissect a tendinous strip. This is passed below the sartorius muscle near the first incision. A large needle is used to draw it through the walls of the canal, and the extremity of the tendinous band is fixed to the thickness of the pyramidal and rectus muscles by two metallic points, including the skin. Suture of the two cutaneous wounds is then practiced.—*Marseille-Médical*, November 15, 1896.

New Aloes Test for Chemico-legal Purposes.—PIERRE APÉRY, of Constantinople, gives an account of a new method discovered by him. The suspected preparation (paste, pills, powder, etc.) is reduced by the aid of alcohol and filtered, after which the alcoholic tincture is evaporated and the remainder recovered by means of hot water. The watery solution is likewise filtered and treated with an excess of acetate of lead. The product is again filtered and the solution concentrated by evaporation in a water-bath, after which a small quantity of carbonate of soda is added to precipitate the excess of lead-salt. After filtration the liquid is neutralized by several drops of acetic or nitric acid. If then, several drops of a weak solution of perchloride of iron are added, a reddish-brown tint is immediately obtained, which is the deeper in proportion to the quantity of aloes contained in the liquid. The sensibility of this reaction is very great, for 1 part of aloes in 2000 or 3000 parts of water will give a perceptible tint.

New Perchloride-of-Iron Test for Medico-legal Purposes.—APÉRY also recommends a new process for the recognition of perchloride of iron in combination with other iron salts. It consists in heating the solution, weakened by the adding of water. The solution when heated assumes a reddish brown color, resembling that of onion-peel.

Recent Suggestions in Therapeutics.

Gastric and Intestinal Disorders.—John Aulde, of Philadelphia, recommends *hydrozone* in gastritis, either acute, subacute, or chronic. He states that in these cases we have to deal with an unhealthy condition of the lining membrane of the stomach. The inflammation is attended with an increased output of mucus, which seriously interferes with the normal functions of the peptic glands. By the introduction of a small quantity of *hydrozone*, in the strength of 1 part to 32 parts of boiled or sterilized *water*, this objectionable mucus is at once destroyed by the action of the oxygen which is released, and the contents of the stomach remaining are promptly discharged into the small intestines.

A patient suffering from gastritis should take at least half an hour before meals, from 2 to 4 ounces of diluted *hydrozone* (1 to 32) and lie on the right side so as to facilitate the action of the stomach in discharging its contents. The antiseptic properties of *hydrozone* thus used are sufficient to destroy the micro-organisms and leave the stomach in a healthy condition for the absorption of nutritive pabulum. (*New York Medical Journal*, August 15, 1896.)

Internal Baths in Typhoid Fever.—H. Duchenne recommends the following procedure: (1) allowing the patient to drink all he wants (upon this point everyone appears to agree) of inert liquids, such as *ptisans*, slightly-acidulated drinks, *water* slightly colored with *red wine*, and weak *grog*; (2) giving a daily tepid enema (from ½ to 1 quart—litre). For the suggestive effect 10 grains (0.65 gramme) of *sulphate of quinine* in two doses are given, and a small quantity of weak carbolized *water* (2.50 per cent.) is placed in the injection.

The results are as follow: Rapid diminution of the diarrhœa; lowering of the fever, which rarely exceeds 39° C. (102.3° F.) after the fourth and fifth day of treatment; convalescence at the end of twenty-one days, on an average. *Diet: milk*, no bouillon, which is a poison, unless very fresh, when the kidneys are affected; no feculent substances, or soups made without meat. From 2 to 4 quarts of *milk;* 2 or 3 weak *grogs;* no astringents, not excepting wine. (*Bull. Gén. de Thérapeutique*, October 23, 1896.)

Iodide of Potassium in Cholelithiasis.—This remedy was successfully used by T. Dunin in one hundred cases of biliary calculus during the past four years. The best results were obtained, not in the cases in which the patients were subject to rare attacks of extremely violent hepatic colic, but in those in which they were more or less constantly troubled with hepatic pain, and where the liver was sensitive to the touch. In the latter cases the favorable effect of the iodide of potassium manifested itself one week after the beginning of the treatment. (*Gazeta lekarska*, No. 22, 1896.)

Syncope Caused by Intubation of the Glottis.—Poulet, of Plancher-les-Mines, advocates, when this occurs in children, repeated blows upon the back and præcordial region, the child being held with the head downward. At the end of a minute respiration is re-established, and very soon the patient has regained his normal condition. The author reports a case. (*Bull. Gén. de Thérapeutique*, November 8, 1896.)

The Treatment of Pronounced Neurasthenia by Psychotherapy.—Three cases are cited by Valentin, the first being one of old postgrippal origin, which were cured in several sittings of hypnotic suggestion with deep sleep. In the second case there were serious neurasthenic disturbances due to the menopause, which were overcome after twenty sittings of suggestion with slight hypnosis, unaccompanied by amnesia on awakening. In the third instance there was visceral neurasthenia associated with signs of mental degeneration, which required a treatment of three months by suggestion in the waking state in order to bring about the complete disappearance of the trouble. (*Bull. Gén. de Thérapeutique*, November 15, 1896.)

☞ *Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."*

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

28 RUE DE MADRID, PARIS, FRANCE.

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(End of Editorial Department of Journal for December, 1896.)

A REMARKABLE CURE OF CARBUNCLE.

Dr. Thomas Page Grant, of Louisville, Ky., has reported a very successful experiment with Protonuclein which is of decided interest. According to *The International Journal of Surgery*, Dr Grant was able to cure in four days, with the aid of Protonuclein Special, a carbuncle two inches in diameter and covered with pus. The patient had suffered with the same trouble before and there was no doubt as to an excellent prospect for a two or three weeks' experience.

The doctor's method was as follows: First, a free incision across the top of the carbuncle, followed by evacuation and cleansing with a solution of carbolic acid 3 to 5 per cent. Afterward the broken down tissue was removed with dressing-forceps. The wound being cleansed thoroughly, it was packed with dry Protonuclein Special. A poultice of flaxseed meal on which was a teaspoonful of fluid extract of eucalyptus globulus was then applied. An iron and strychnine tonic was ordered and the local treatment continued for two days, when the poultice was left off and an ointment used instead.

The case was dismissed in four days practically cured, although the patient was advised to apply the ointment for a few days to prevent local irritation.

THE TRINITY OF THERAPY.

In a communication under the title "The Trinity of Therapy," Dr. Thomas Osmond Summers, of St. Louis, Mo., writes that the three great therapeutic principles have been met fully by the modern method of pharmacal science. The first in extraction of Phaselin; the second in the chemical combination of Rheumagon, and the third in the strong phosphatic product, the triumph of modern chemistry, to which, for some reason unknown to us, the name Melachol has been given; but without doubt we have here the trinity of therapy.

This trinity of therapy to which we refer is distinctively represented by the normal therapeutic agents which cover the physiological division of the organism. First, the fibro-areolar tissue, which is the groundwork of the organism upon which all of the structures are built. Second, the nerve tissue, which controls the distribution of nutrition and regulates the balance of function in the organism. Third, the digestive principles, which furnish the material for structure and the stimulus for function.

They are the necessary constituents or the proximate principles of the body, and without them it would starve, shrivel, decay, and die As an example of this it is only necessary to refer to chloride of sodium, the deprivation of which would produce as certain death as a rifle ball through the heart. It is, therefore, the province of therapy to provide proper and assimilable combinations of those inorganic materials.

The *Journal of the American Medical Association* for November 7th contains a most timely article by J. Homer Coulter, A.M., M.D , Ph.D., of Chicago. The subject is "Quinsy; the Differential Diagnosis and Treatment." This paper clearly and concisely presents the author's views as to quinsy, its resemblance to tonsillitis, and the various points of dissimilarity. The anatomy of the tonsil is explained in a novel manner and the pathology of both conditions reviewed; but the most interesting portion of Dr. Coulter's article relates to the treatment. Dr. Coulter says that a year or so ago he had three cases present themselves from the same house that were clearly produced by the same cause,—viz., a broken window on a cold, damp day. All were suffering intense pain, two of them having typical cases of quinsy and one tonsillitis. The stereotyped treatment was carried out for thirty-six hours, with the result that the patients grew steadily worse. The tonsillitis was then relieved by free incision, but in the cases of quinsy it afforded no relief. Dr. Coulter then prescribed Lactophenin for the two quinsy cases, the dose being 10 grains every three hours; after the second dose one of the quinsy patients was almost entirely relieved of pain, the temperature approaching normal. The other patient was relieved by the third dose quite as completely, evacuation of the pus being possible, followed by cleansing of the cavity. Since that time Dr. Coulter has used this remedy in twelve cases of quinsy, with perfect success in all save one instance. The average time of relief has been about four hours. No other medication has been used except a mercurial cathartic. This is certainly a commendable showing for Lactophenin.

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